

**Termination in therapy: A comparison of Cognitive Behaviour Therapy
and Interpersonal Psychotherapy**

Hannah Ruth Worthington

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‘This thesis has been composed by myself and the work contained herein is my own’.

Abstract

Introduction: A significant amount of literature and research exists exploring the development of the therapeutic relationship in psychotherapy, however in comparison literature on termination remains relatively lacking. This study compares Interpersonal Psychotherapy (IPT) and Cognitive Behaviour Therapy (CBT) on various components of termination and also aims to correlate amount of termination activity with therapeutic outcome. **Method:** A content analysis of 42 final (or penultimate) therapy sessions was carried out using a coding scheme derived from the Termination Behaviour Checklist – Therapist (Quintana & Holahn, 1992). Qualitative analysis sought to illustrate quantitative findings in more detail. **Results:** Overall there was a significantly greater amount of termination activity in IPT sessions compared to CBT. In particular, specific findings were significantly more evaluation of therapy, closure of the therapeutic relationship and greater patient expression of affect, in IPT in comparison to final sessions of CBT. There was no significant difference between therapeutic interventions in terms of discussion of the patient's future. A significant positive correlation between amount of termination activity and a reduction in symptoms of depression was found. **Conclusions:** These findings are consistent with theoretical orientation, in which IPT explicitly defines a phase of termination of therapy and a cognitive-behavioural approach emphasises relapse prevention. Implications are for a greater focus on other aspects of the termination process in CBT. In addition the finding that amount of termination activity was related to a reduction in symptoms of depression, alerts therapists to an awareness of managing termination when patients have not experienced an expected improvement in presenting symptoms.

1. Introduction

This thesis is about psychotherapies in the National Health Service (NHS). There are various different types of psychotherapy which vary in their theoretical underpinnings and clinical application. However the therapeutic relationship between patient and therapist is crucial to the process of all types of psychotherapy and much has been written on the development of the therapeutic relationship, or alliance. Stiles, Shapiro & Elliot (1986) suggest that 'all psychotherapies are equivalent' in that regardless of the type of psychotherapy, the common factor between them is the therapeutic alliance and this has an equivalent impact on outcome. The National Institute of Mental Health Treatment of Depression Collaborative Research Program (Elkin et al., 1989) was a large multi-centre trial which studied the effectiveness of a variety of treatments for depression including two different psychotherapies; interpersonal psychotherapy and cognitive therapy; and medication. The findings were that the outcome across all treatments was similar. If the outcome of psychotherapy is largely dependent on the relationship developed between therapist and patient during psychotherapy, the ending of this relationship, the termination phase of psychotherapy, is likely to be of importance. However there is a comparative lack of research on the termination phase in psychotherapy. This study is about termination in two different types of psychological therapy used widely in the NHS; interpersonal psychotherapy (IPT) and cognitive behaviour therapy (CBT).

The introduction will briefly consider what psychotherapy is, before defining and outlining the importance of the therapeutic relationship and the termination phase in psychotherapy. Theoretical perspectives on termination in psychotherapy and on the ending of relationships in general are considered before a more in depth examination of

the empirical research on termination in psychotherapy; therapists' management of termination in psychotherapy; and how IPT and CBT approach termination.

1.1. Definitions and significance

1.1.1 Psychotherapy

Psychotherapy has the aim of reducing psychological distress at its core. The process involves patient and therapist engaging collaboratively in a process of exploration and discovery. There are various different types of psychotherapy. Broadly speaking these can be divided into psychological therapies (including CBT and IPT); psychodynamic psychotherapy (including psychoanalysis); and counselling. In the NHS psychological therapies and psychodynamic psychotherapy are prevalent. Whilst psychodynamic psychotherapy emphasises the role of past relationships influencing present difficulties, psychological therapies are generally more focused on current, here and now difficulties. Psychological therapies tend to be short term, ranging from 12-20 weekly/fortnightly sessions, whilst psychodynamic psychotherapy ranges from 6 months to several years (in the case of psychoanalytic psychotherapy) on a weekly or several times a week basis. It is beyond the scope of this study to explore the differences between these therapeutic approaches in more detail.

All types of psychotherapy aim to establish a therapeutic relationship between patient and therapist. The therapeutic relationship is discussed in the following section.

1.1.2 Therapeutic alliance (relationship)

The importance of the 'therapeutic alliance', 'therapeutic relationship' or 'working alliance' in psychotherapy has been widely recognised, in clinical practice, theory and in an abundance of quantitative research. It has been shown to be one of the most powerful

predictors of outcome in psychotherapy, regardless of the type of therapy investigated (Catty, 2004; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Luborsky, Singer & Luborsky, 1975).

There have been various definitions of the concept depending on theoretical perspective. Psychodynamic origins of the therapeutic relationship are evident in Freud's 1912 discussion of the value of the analyst being seriously interested in and sympathetically understanding of the client, to facilitate the development of a positive attachment to the analyst. Greenson (1965) developed this idea further and suggested there was a working alliance component of the relationship that was distinct from aspects of the relationship that were inevitably influenced by the client's past relationships; or transference. The alliance

'permits the client to step back and use the therapist's interpretations to better distinguish remnants of past relationships and the real association between himself or herself and the therapist' (Horvath & Luborsky, 1993, p.2)

An alternative conceptualisation of the therapeutic relationship, from a client centred perspective, suggests that the therapist's empathy, unconditional positive regard and congruence are essential and sufficient conditions for therapeutic change (Rogers, 1961). These therapeutic conditions alone are thought to have curative properties.

'If I can provide a certain type of relationship, the (patient) will discover within himself the capacity to use that relationship for growth, and change and personal development will occur' (Rogers, 1961, p 33).

Although Catty (2004) states that these conditions are conceptually different from the therapeutic alliance, research has suggested that there is a clear overlap (Horvath & Luborsky, 1993).

The 'Pantheoretical Concept of Alliance' is derived from psychotherapy research suggesting that different therapies produce similar amounts of therapeutic gains (Smith & Glass, 1977; Stiles et al., 1986). This refocused interest on the therapeutic relationship as a factor responsible for this common variance between different types of therapy. Bordin's (1979) pantheoretical model of the therapeutic alliance takes account of different psychotherapeutic approaches, emphasising collaboration and shared goals as important factors. The relationship makes it possible for the patient to accept and follow treatment, rather than being curative in itself as Rogers' (1961) client centred perspective suggests. He defines the therapeutic alliance in terms of three areas: goals, tasks and bonds. Whilst the latter relates to the positive attachment component of the relationship, the former two are distinct components of the collaborative nature of the therapeutic relationship; for example 'tasks' refer to the behaviours, thoughts and beliefs that happen during therapy; and goals refer to patient and therapist mutually valuing particular targets of therapy.

Empirical research has frequently aimed to relate the therapeutic relationship to outcome in psychotherapy. A recent increase in studies of the therapeutic relationship, has arisen partly as a result of the development of reliable methods of measuring the concept. Currently there are at least 11 alliance assessment methods (e.g. Gaston & Ring, 1992; Horvath & Symonds, 1991; Marziali, 1984a). Horvath & Symonds (1991) carried out a meta-analysis of the relationship between the therapeutic alliance and outcome in psychotherapy. The authors identified over 100 studies dealing with the relationship aspect of counselling and psychotherapy and reviewed 24, based on defined inclusion criteria. Their findings therefore are robust in that they stem from studies with strong

methodological design. Overall they conclude that the working alliance is a 'relatively robust variable, linking therapy process to outcome' (Horvath & Symonds, 1991, p 146).

Two critical phases of the alliance have been identified to inform therapeutic work with patients; the initial development of the alliance, taking place within the first five sessions (Saltzman, Leutgart, Roth, Creaser & Howard, 1976); and the phase during which the therapist begins to challenge the patient, which can lead to ruptures in the alliance (Safran, Crocker, McMain & Murray, 1990). Research to date has not identified the end of therapy as a 'rupture' in the alliance, although this idea will be discussed in more detail in following sections.

In their review of the role of the therapeutic alliance in psychotherapy, Hovarth & Luborsky (1993) also discuss research on factors of the alliance that are specific to different types of therapy; and client and therapist factors influencing the development of the alliance. The interest and emphasis in the literature on the therapeutic relationship, across different types of therapy highlights its significance in the process of psychotherapy. The end of this relationship is considered in the following sections.

1.1.3 Termination in psychotherapy

Fortune (1987) defines termination of psychotherapy from a social work perspective;

'Termination becomes a phase of the treatment process when client and practitioner reach some understanding that the contact between them will end. At this point, the quality and content of the therapeutic interaction changes, with increased activity, a focus on affect associated with ending, and reorientation to life outside the treatment relationships' (Fortune, 1987, p 159).

The author highlights that ideally the decision to end therapy is a mutual one and has implications for the content of the therapeutic dialogue. Bolen (1972) comments that termination should involve gradual weaning of the patient from the relationship with the

therapist. Problems encountered with this process are discussed explicitly and the therapist's responsibility is to help the patient separate from him/her and to disengage from the treatment process. Forced termination refers to any situation in which external factors, outside of the patient's control, decide when psychotherapy will end. In this respect the decision is not mutual and this often happens when a therapist leaves due to training requirements, moves jobs (Penn, 1990; Siebold, 1991) or the therapy is time-limited as is the case for psychotherapy provided by the NHS.

In terms of the duration of the termination phase, there is disagreement as to how long this can take, ranging from two to four sessions, to six months depending on whether therapy has been short or long term (Bossset & Styrsky, 1986; Miller, Frank, Cornes, Imber et al., 1994).

1.1.4 The importance of the termination phase in psychotherapy

The importance placed on this phase of psychotherapy is dependent on the type of therapeutic approach adopted. In general, psychodynamic psychotherapy places a greater emphasis on this phase of therapy than other types of therapy.

'Termination is more than an act signifying the end of psychotherapy; it is an integral part of the process of psychotherapy and, if properly understood and managed, may be an important factor in the instigation of change' (Ward, 1984, p 21).

Ward (1984) suggests that the termination phase is crucial to the maintenance of therapeutic change (Levinson, 1977; Ward, 1984; Yalom, 1975). Termination in psychotherapy also resonates with previous endings experienced during life, whilst potentially being a rehearsal for inevitable future experiences:

'Termination of psychotherapy can be thought of as a recapitulation of the multiple preceding goodbyes of living. At the same time it is a preparation for being able to deal more adequately and openly with future goodbyes' (Maholick & Turner, 1979 p 25).

A variation on this view is that the emphasis placed on the termination phase of psychotherapy should be in accordance with the nature of the therapeutic relationship, its focus, and the goals of treatment. When psychotherapy gives termination a central focus, this is because it is viewed as being a crucial time for patients in coming to terms with loss and anticipated separation (Pinkerton & Rockwell, 1990).

1.1.5 The lack of research on termination in psychotherapy

Empirical research on termination and literature on the subject in general is relatively sparse, as has been commented on by many authors (Marx & Gelso, 1987; Quintana & Holahan, 1992; Roe, Dekel, Harel, Fennig & Fennig, 2006; Ward, 1984). This may be a direct reflection of the relatively reduced emphasis of importance of this phase of therapy, particularly when psychotherapy is of a shorter duration (Miller et al., 1994). It has also been attributed to anxiety on the researcher and clinician's behalf regarding the ending of relationships, which can evoke uncomfortable feelings, leading to reluctance to investigate this area (Martin & Schurtman, 1985). Much of the existing literature and research comes from a psychodynamic or counselling perspective.

In the following section a theoretical perspective on termination in therapy is discussed.

1.2 Theory of termination in psychotherapy

1.2.1 A psychodynamic perspective on termination in psychotherapy

In psychoanalysis, initially there was no emphasis on the importance of the loss of the relationship that had developed between patient and analyst. This view came from the underpinnings of the psychoanalytic process that was reliant on analyst neutrality, a

patient becoming attached to their analyst being seen as a lack of therapeutic neutrality (Shapiro & Ginzberg, 2002). Much of the psychoanalytic literature addresses how to know when it is time to end analysis.

1.2.2 Freud's thoughts on termination in psychoanalysis

In his early career, Freud did not regard termination as an important phase in psychotherapy (Kupers, 1988). The author describes the outcome of two famous cases, Anna O and Dora, in which unresolved termination issues led to the failure of the therapeutic changes achieved during analysis.

In 'Psychoanalysis Terminable and Interminable' (Freud, 1937), Freud focuses on how to know when is the best time to end long term psychoanalysis with a patient, and if this is ever achievable. To summarise he argues that 3 requirements should be broadly met; first the patient is no longer suffering from distressing symptoms; second, there is an indication that these symptoms will not reappear; and third, the patient is not likely to experience any further significant change by continuing the analysis. Kupers (1988) argues that this is such a definitive understanding of termination, it has 'never been supplanted in the literature of psychoanalysis and psychotherapy' (Kupers, 1988, p.22). Rather subsequent literature has focused on detailing how a clinician might know when the criteria have been satisfied. Certainly it seems to reflect a suggestion that the decision to end psychoanalysis is dependent on some sort of cure, or change for the better; a belief that relapse will be minimal or not at all; and that further psychotherapy will not produce any further benefit to the patient.

In terms of incorporating psychoanalytic ideas into an understanding of the termination phase of psychotherapy, Freud's writing on 'Mourning and melancholia' (Freud, 1915)

provides an explicit link between the loss of a relationship and the experience of depression. In the latter case the suggestion is that the depressed person has lost regard for himself. His self reproaches can be said to apply to;

‘someone whom the patient loves or has loved or should love’ (Freud, 1915, p.53)

The ego then identifies with the lost ‘object’ (person) and the anger and self reproach is directed towards the self. Freud highlights the importance of feelings of ambivalence towards the loved object that is lost, which can become problematic and lead to ‘pathological mourning’. There is an overall suggestion however that the loss of a loved one provides the opportunity for development of the personality, the process of loss can be healthy or unhealthy. This is an important factor that re-emerges in the literature on termination of psychotherapy. In a similar vein, the end of psychotherapy, potentially evoking feelings of loss, can similarly be productive therapeutically or destructive, if not handled sensitively.

1.2.3 Termination as loss

Orgel (2000) describes attachment and loss as important themes in the termination phase of psychotherapy. He suggests, in what might be considered a more contemporary view of the psychoanalytic perspective on termination, that from the very beginning, analysis activates a mourning process. As the relationship develops between patient and analyst, inevitably this is always with the knowledge that this relationship will come to an end. It is then that the patient is able to internalise the relationship and in the post termination phase, develop skills in self analysis. The author acknowledges that termination has a mutual impact on both patient and analyst, albeit to varying degrees; ‘no analytic pair ever gives up the relationship easily’ (Orgel, 2000, p.724).

Balint (1950) was one of the first to acknowledge the loss of the therapeutic relationship as a crucial aspect of the termination of analysis. He describes the clinical difficulty in achieving a complete, successful termination of analysis and discusses some of the criteria that 'should' be attained, during termination, but then admits that in reality these are perfectionist and unrealistic standards. In terms of termination in psychoanalysis being experienced as a loss, or even a crisis, he acknowledges the event as a 'deeply moving experience', for both patient and analyst. He writes about the process;

'...the general atmosphere is of taking leave forever of something very dear, very precious – with all the corresponding grief and mourning – but this sincere and deeply felt grief is mitigated by the feeling of security, originating from the newly-won possibilities for real happiness. Usually the patient leaves after the last session happy but with tears in his eyes and, - I think I may admit – the analyst is in a very similar mood' (Balint, 1950, p.197).

The loss metaphor is evident, however Balint also recognises the mixed emotions of patients who are able to approach their life differently as a result of analysis.

Freud was criticised by other psychoanalysts for his neglect of the impact of the loss of the relationship at the end of psychoanalysis. Orgel (2000) highlights Freud's reluctance to address how patients became attached to him, as if this might undermine the process of analysis and compromise his role within the relationship. Freud's focus on how to know when to end analysis has since been described as idealistic and unrealistic seeing as in very few cases is a 'true ending' ever achieved (Balint, 1950). In a similar vein the focus on termination of psychotherapy as a loss event may be considered romantic and idealistic and not necessarily relevant (Sifneos, 1972). It presupposes that there is time to build a strong and meaningful therapeutic relationship. In short term psychotherapies, used frequently in the NHS, this may not always be the case and as a result there is a

reduced emphasis on the termination phase of psychotherapy (Miller et al., 1994). Quintana (1993) argues that the termination as loss model is outdated and unsupported by empirical data, as will be discussed in greater detail in section 1.4. He suggests that this has led to a 'stagnation' of research on termination and the theory is in need of updating. In the following section the ending of relationships in general is discussed from a theoretical perspective. This provides a basis for the idea that the end of any relationship, once established, is important

1.3 Theoretical perspectives on the ending of relationships

1.3.1 Attachment theory, separation and loss

'Anxiety in children, is originally nothing other than an expression of the fact that they are feeling the loss of the person they love' (Bowlby, 1973, p.54).

Bowlby (1969) first made observations of how young children react when separated from their mother. Children as young as 6 months will respond with 'protest, despair and detachment' during prolonged separation from their maternal caregiver (p.49, Bowlby, 1969). He argued that this was a consequence of there having developed between mother and infant, an innate, strong and affectionate bond leading to psychological distress when broken.

Bowlby described infant attachment behaviour as sucking, clinging, following, crying and smiling, designed to maintain proximity to the mother. A secure attachment to a caregiver promotes exploration and investigation in the child, who consequently learns about people and the world. Attachment is initially between child and parent (or caregiver) and later becomes between adult and adult. Attachment behaviour exists throughout life. In Separation-individuation theory Mahler (1975) described how movement is crucially important for the infant who is able to explore his surroundings,

paving the way for separateness and eventually individuation, identity and autonomy. The process of separation is therefore viewed as vital for development and is reliant on the mother being able to let go, while remaining available so the child does not go too far too soon (Blum, 2001).

A parallel to this idea is that the security experienced in a therapeutic relationship enables the patient to explore relatively unknown, psychological territory, such as difficult feelings and experiences.

‘So long as a child is in the unchallenged presence of a principal attachment figure, he feels secure (p.257, Bowlby, 1969).

Bowlby comments that threat of loss arouses anxiety and actual loss gives rise to sadness and a process of mourning; while each of these situations is likely to arouse anger. He suggests that the function of anger is to assist the individual to overcome any obstacles there may be to reunion; and also to discourage the loved person from going away again.

Bowlby’s theory of attachment suggests that if a child experiences repeated, prolonged and/or permanent separation from an attachment figure, or is never given the opportunity to develop a close bond with an attachment figure, they are at risk of experiencing psychological difficulties. This is due to individuals developing an internal working model of attachment that is relatively stable and enduring and is based on early childhood experiences of care giving.

The loss of a relationship in which an attachment has developed can lead to the experience of difficult emotions. During the ending of a therapeutic relationship, the experience may be resonant with previous losses and therefore may be particularly pertinent.

Attachment theory is based on the experimental observation of the impact of separation, on children at different ages, across different cultures. Bowlby used the empirical method to develop his ideas about the ending of relationships, which is relatively absent in psychoanalytic theory and this has leant it credibility as a theory. However at the time he was ostracised from the psychoanalytic community and his ideas are still viewed by some psychoanalysts as controversial. Broadly it is argued attachment theory places too much emphasis on external events, such as separation and loss, to the exclusion of the traditional psychoanalytic focus of the internal world of the individual (Bowlby, 1980; A.Freud, 1960; Gullestad, 2001) or other important aspects of the mother infant relationship (Blum, 2001). Attachment theory has however become a widely respected basis for understanding and treating psychological distress and its emphasis on the interpersonal perspective is considered extremely important.

Attachment theory has provided the basis for a theory of how people cope with bereavement, as will be discussed in the following section.

1.3.2 Grief

Perspectives on grief provide an additional illustration of how an individual copes with the end of a relationship, which informs the understanding of the termination phase of psychotherapy. In 'Attachment and Loss' (Bowlby, 1980) healthy mourning following the loss of a loved one is described as;

'in some degree at least, a withdrawal of emotional investment in the lost person, that they may prepare for making a relationship with a new one' (Bowlby, 1980, p 25).

There is an inevitable combination of sadness, hope for the future, and anxiety that hopes for the future are fulfilled. Anger with the person lost, and aggression is also experienced as a natural part of the process of mourning, with the function of achieving reunion.

Mitigation and minimisation are important components of the early stages of the mourning process. Parkes (1975) describes 'mitigation' whereby the bereaved person minimises the impact of the loss. The most common example of this is of having a sense that their loved one is nearby, providing them with comfort and a temporary relief from their distress. For the bereaved, 'until the reality of the loss has been fully accepted, the greatest danger is the danger of the loss itself' (Parkes, 1975, p.102). This coincides with an idea of 'anticipatory grief theory' (Schoenberg, 1974). The theory suggests that the period prior to mourning is important, actual mourning potentially not taking place until after the loss has occurred.

In the later stages of grieving, Parkes (1975) describes the process of gaining a new identity following the loss of a loved one. Bereavement can therefore imply a major change in lifestyle. An example is the newly bereaved widow who potentially confronts a new set of expectations regarding taking on tasks that previously her husband would have done.

Coping with the loss of a loved one and the end of any relationship can also be understood as a time of transition.

1.3.3 Transition

Hopson & Adams (1976) describe some ideas about transition. The significance of people's experiences being in a state of ongoing flux during life is highlighted, particularly during certain life stages such as adolescence and the menopause. These transition points offer a great potential for personal growth and development, whilst inevitably triggering psychological distress at times. Transitions typically include

bereavement, marriage, birth, divorce, career change, moving house or job. Transition is defined as 'a discontinuity in a person's life space' (Hopson & Adams, 1976, p.5).

'For an experience to be classed as transitional there should be:

- i) personal awareness of a discontinuity in one's life space
- ii) new behavioural responses required because a situation is new, or the required behaviours are novel, or both' (Hopson & Adams, 1976, p.6).

Hopson & Adams (1976) describe a phase model of transition, as they suggest the experience triggers a cycle of reactions and feelings. Seven distinct phases are described although it is important to note that these are not necessarily separate and sequential in occurrence. The first phase is '*immobilisation*', a sense of being overwhelmed, or in shock. In order to move out of this phase the individual characteristically '*minimises*' the change, or even will deny that such an event is happening. The authors suggest that this is an important and necessary phase of coming to terms with change. As the reality of the change is accepted, the third phase involves an emotional response of '*depression*', as the individual realises what is involved and contemplates the future. The initial three phases described are similar to the stages of grief described by Bowlby.

The following four phases however explain a more positive, coping response to transition. The focus is on the positive, adaptive experience of change. The fourth phase involves '*accepting the reality and letting go*' of the previous role. In the fifth phase the person becomes much more active and starts '*testing*' out the new role, trying out new behaviours, new lifestyles. Following this relatively energetic phase the person will try to '*seek meaning*' and understanding of the transition, of what it personally means to them. This is a cognitive process which allows the individual to finally '*internalise*' these

meanings and incorporate them into their behaviour. Overall the emphasis is placed on the potential for growth that can come about as a result of change, or loss.

Quintana (1993) suggested that the end of psychotherapy need not necessarily be understood as a time of crisis. He makes a recommendation that termination be understood as a process of transformation. The literature on transition gives this idea support.

1.3.4 Summary

Termination was not always viewed as important from a psychodynamic perspective. Freud only acknowledged its importance in the later stages of his life, and at this time became interested in how to know when to end analysis. A more contemporary view is that the end of psychotherapy, and the therapeutic relationship, can be experienced as a potential time of loss and therefore associated with feelings of sadness, anxiety and anger. Attachment theory and a model of grief are used to describe the psychological impact of the ending of relationships in general, in the relative absence of theoretical literature specifically on termination in psychotherapy. A termination as loss model has been the focus of traditional psychodynamic theory, however this is not to say that patients do not also experience termination in a more positive light and transition theory has provided a useful framework in which to consider termination of psychotherapy. Despite the lack of research on termination in therapy, in the following section existing empirical findings are presented and discussed.

1.4 Research carried out on termination in psychotherapy

1.4.1 Emotional responses to termination in psychotherapy

Roe et al., (2006) explored clients' feelings during termination of psychodynamic psychotherapy and related these feelings to satisfaction with psychotherapy. Feelings were assessed on a self report basis and allowed clients to openly express their reactions, as opposed to being restricted to particular questionnaire response categories. The average length of time in therapy was 27 months. Results show that clients experience a wide range of feelings during termination in private practice psychodynamic psychotherapy and many of these are positive, related to independence, positive aspects of the therapeutic relationship, gains the client has made during psychotherapy and satisfaction with psychotherapy (Baum, 2005; Fortune 1987; Fortune, Pearlingi & Rochelle 1992; Martin & Schurtman, 1985; Marx & Gelso, 1987; Quintana & Holahan, 1992; Webb, 1985). Roe et al., (2006) described feelings of pride, gratitude, excitement, pleasure, eagerness and emotional relief, in combination with newly gained self knowledge, emotional strength, recognition of feelings and the ability to express the need for autonomy. These findings have been supported in a recent review of the research on psychotherapy termination (Gelso & Woodhouse, 2002) and reflect the theoretical perspective on transition described in section 1.3.3, which highlights the positive and adaptive experience of change, letting go and moving on.

Clients also experience feelings of sadness, anger, rage, frustration, abandonment, depression and anxiety during the termination of psychotherapy (Baum, 2005; Bywaters, 1975; Fortune et al., 1992; Kramer, 1986; Ward, 1984). Roe et al. (2006) found that clients who did not feel therapy was helpful or successful, or that the therapist was

accepting and respecting of their decision to end therapy were more likely to experience negative emotions such as frustration and anger. Loss of a meaningful relationship was the most frequently mentioned factor contributing to negative feelings such as sadness and a feeling of abandonment. These findings highlight the parallel between Bowlby's ideas about the impact of separation and loss on a person when a relationship ends; grief theory; and termination of psychotherapy described as a loss experience, as was explored in sections 1.2 and 1.3.

'there is often a keen sense of shame for caring so much about losing this person who apparently leaves them with ease and with whom they have only a professional 'business' relationship, a belief that such feelings are infantile, irrational, and unacceptable.' (Penn, 1990; p380).

Anthony & Pagano (1998) describe a clinical case from a psychodynamic perspective, in which the management of termination for a 15 year old girl was used therapeutically to maintain the growth she had made during psychotherapy.

'The client's attachment (to the therapist) led to a termination which integrated hurt, anger and connection into one experience' (Anthony & Pagano, 1998, p.281)

Rather than splitting her feelings, with the therapist either being viewed as completely good, or bad respectively. This client's growth revealed that it is possible for a therapeutic termination to be a 'balm for old wounds' (Anthony & Pagano, 1998, p.282).

1.4.2 Behavioural responses to termination in psychotherapy

Marx & Gelso (1987) assessed the self reported reactions to termination of clients (mostly students) who had attended a university counselling centre for an average of 10 sessions. Counsellors used a range of different psychotherapeutic approaches. They found that termination behaviour typically consisted of reviewing therapy, thinking about the future and saying goodbye. Clients also evaluated the progress of treatment and the

quality of the therapeutic process and engaged in constructive activity outside of the therapeutic relationship (Flapan & Fenchel, 1987; Fortune et al., 1992; Lanyado, 1999; Quintana & Holahan, 1992). These behaviours are often therapist initiated and are discussed in more detail in section 1.5.

In terms of more problematic reactions, clients may raise new concerns during termination, experience temporary symptom relapse or development of new symptoms, underestimate the amount of progress made during psychotherapy, devalue or idealise the psychotherapy/therapist and generally engage in negative ways of avoiding the end of psychotherapy (Elbow, 1987; Frieston, 1974; Garland, Jones & Kolodny, 1973; Levinson, 1977; Northen, 1988; Quintana and Holahan, 1992). This desire to avoid the ending can be understood in terms of reluctance to experience uncomfortable feelings associated with loss, as Bowlby described in his proposed attachment theory (Bowlby, 1969). It might also illustrate a process comparable to mitigation and minimisation components of the grief process, as described by Parkes (1975), referred to in section 1.3.3. Baum (2005) defines 'resistance behaviour' during the latter psychotherapy sessions as missing sessions, being late, being silent and openly discussing termination and separation. In contrast 'holding behaviour' is defined as raising new problems, introducing new symptoms, expressing the need to continue treatment and re-experiencing previous losses (Baum, 2005, p 314).

Fortune et al., (1992) asked 69 social workers about termination reactions in their most recently terminated individual case. Psychotherapeutic interventions were varied and the average time in therapy was 12 months. They found that client reactions were mostly positive, but also often ambivalent:

‘weak negative reactions are present in most cases, usually as part of the ambivalence about terminating’ (Fortune et al., 1992, p 176).

Penn (1990) raises an interesting point about the indirect expression of patients’ reactions to termination. This is described as material that the patient brings for discussion that superficially might seem irrelevant, but may have a similar theme related to termination, e.g. anger, separation anxiety and loss. An alternative way of understanding this aspect of termination, in psychodynamic terms, would be in terms of unconscious communication, to be acknowledged and interpreted by the therapist (Casement, 1985; Malan, 1979).

1.4.3 Factors influencing both emotional and behavioural responses to termination

Baum (2005) investigated the association between clients’ emotional and behavioural responses to treatment termination and variables such as the source of termination (client, therapist or external source); the termination process; and the perceived outcome of therapy. Participants were student and qualified social workers, asked to comment on the variables described. Termination process and perceived outcome of therapy included participants’ perceived sense of client control, centrality of the therapeutic relationship to the client, client choice, client desire, reaching the goals of therapy and failure of therapy. The average time in therapy was 20 weeks and the study does not report what kind of therapeutic intervention was used.

Findings were that clients who initiated termination had lower positive feelings (satisfaction, pride, hope, happiness and sense of success) and clients whose termination was initiated by their therapists, showed stronger hurt and anger than others (Fortune et al., 1992; Penn, 1990; Siebold, 1991; Suarez, 1978).

In terms of the termination process clients whose treatment was terminated abruptly, perceived little choice in the termination and who felt that therapy had been a failure

responded with feelings of self doubt and sorrow (Marx & Gelso, 1987). Clients for whom the therapeutic relationship was central responded with a combination of negative and positive feelings, reflecting the ambivalence people feel in ending important relationships (Fortune et al., 1992; Marx & Gelso, 1987). Fortune et al., (1992) comment that the more clients viewed psychotherapy as successful and were satisfied with psychotherapy, the more likely they were to report conflicting feelings regarding termination.

In terms of behavioural responses, reduced client control in the termination process, when initiated by therapist or an external source, was associated with greater resistance and holding behaviours. Similarly the more central the therapeutic relationship to the client and the more the client felt the treatment had failed, the greater the resistance and holding behaviour (Levinson, 1977; Penn, 1990).

Individual factors such as personality and life experiences influence a patient's response to the end of psychotherapy. When a client has a previous history of significant loss the client is more likely to regard exploration of feelings about ending as important (Marx & Gelso, 1987; Webb 1985). Levinson (1977) suggests that external factors, such as current life situation, can influence reaction to termination. However age, gender and length of treatment have not been associated with termination reactions (Baum 2005 ; Bolen, 1972; Elbow, 1987; Northen, 1988).

Therapists often do not emphasize the finality of termination and the client is often offered the opportunity to make contact with the therapist again in the future (Kramer, 1986; Marx & Gelso, 1987; Quintana & Holahan, 1992). This potentially reduces the impact of the ending for the client, who does not fully realise the reality of the loss and

has the relative comfort of future contact with the therapist (or a different therapist). This potentially explains the emphasis in the empirical literature on positive reactions to termination, or the relative absence of negative reactions.

1.4.4 Summary

Most research has found that during termination patients/clients mostly describe positive feelings, rather than negative feelings associated with the loss of the therapeutic relationship. There is also a suggestion that feelings are mixed. Behavioural responses have been categorised according to whether they are problematic or not and research has identified factors which influence the response to termination in psychotherapy; such as the source of termination; the process of termination; and the perceived successfulness of therapy.

Empirical literature on termination of psychotherapy is relatively absent and therefore findings are viewed with caution. There are no studies investigating the termination process in psychological therapies such as cognitive behaviour therapy and interpersonal therapy, which limits the relevance of empirical literature to the present study. All studies are either from a counselling, psychodynamic or social work perspective and particular interventions are rarely specified. Studies also vary in terms of the duration of therapy, from an average of 10 weeks to 27 months. It is suggested that short term psychotherapy explains the emphasis on positive reactions to termination, as there is not enough time to develop a close, meaningful relationship with the therapist (Miller et al., 1994). Only one study used a qualitative approach to explore the termination process in psychotherapy, which means that participants are mostly required to describe their termination reactions in terms of pre determined, structured questionnaire responses, which may inherently bias

responses. Similarly, when therapists commented on the termination process of previous cases, they may have a biased, or inaccurate view of how the patient experienced termination. This concern is partially reduced in that client and therapist report has been found to correlate strongly (Quintana & Holahan, 1992). Marx & Gelso (1987) express surprise at the positive reactions observed and suggest that this may be due to literature being written from the therapist's perspective, indicating their own attitude to ending psychotherapy or a heightened sensitivity to the client's emotional reaction.

Most of the empirical literature focuses on responses to termination, although Quintana & Holahan (1992) investigated the termination process in association with therapy outcome as is described in the following section. Their study provides a rare exploration of how therapists manage the end of therapy.

1.5 Therapist management of termination in psychotherapy

1.5.1 Techniques and strategies

Quintana & Holahan (1992) used a termination activity checklist (the Termination Behaviour Checklist – Therapist) to assess how termination activity related to the outcome of short term counselling cases, of equivalent length (maximum 36 sessions). They identified four components of termination from the literature; discussion of the end of counselling; review of the course of counselling; closure of the counsellor client relationship; and discussion of the client's future plans (Lamb, 1985). A counselling outcome questionnaire was used to assess client outcome and 85 counsellors rated both level of outcome and termination activity of two recently terminated cases. This study is the only one found in which counsellors are counselling psychologists, employing a range of techniques, including a cognitive behavioural approach (13% of participants).

Cognitive Behaviour Therapy is discussed in more detail in section 1.7. Termination behaviours identified in the literature and used as a basis for the original Termination Behaviour Checklist (Marx & Gelso, 1987) are described here:

1. Discussion of the end of psychotherapy

This is understood as the patient's readiness to end psychotherapy (Ward, 1984) and their agreement of when this will happen. The therapist has a responsibility to prepare the patient for the end of psychotherapy by initiating discussion in advance and there is an emphasis on the decision being mutual, wherever possible (Bywaters, 1975).

2. Review the course of psychotherapy

This involves consolidating what has been learned during psychotherapy (Bywaters, 1975; Ward, 1984;). It involves highlighting the changes, therapeutic tools gained and successes that have been noticed and achieved. It considers whether the patient's expectations of psychotherapy have been met and the therapist may provide feedback on the functioning level of the patient compared with the beginning of psychotherapy (Ward, 1984). It may be helpful to summarize major themes that have come up, or to look at accomplishments in psychotherapy, whilst avoiding trying to achieve closure for important themes that may still be around for the patient (Penn, 1990).

3. Closure of the therapeutic relationship

The task for the therapist during termination is to facilitate communication and expression of feelings (Penn, 1990). This involves discussion of the value of the therapeutic relationship, and the associated emotional impact of losing this relationship. Ward (1984) suggests resolving emotional issues and bringing about closure of a significant relationship (Bywaters, 1975). Therapists may be more likely to discuss their

personal feelings about clients when their reactions are mostly positive (when counselling was successful).

4. Discussion of the patient's future plans

This refers to relapse prevention and how to cope with anticipated future difficulties (Bywaters, 1975). There is an emphasis on transfer of what has been learned during psychotherapy, as well as a more positive focus on how the patient will cope independently and how they may feel about the future (Penn, 1990; Ward, 1984). The therapist may provide feedback on difficulties the patient might expect in the future and there may be joint consideration of potential triggers of relapse. Increasing the amount of time between sessions is considered an effective way of preparing the client for life without therapy in the future and may diminish separation anxiety (Suarez, 1978; Ward, 1984).

1.5.2 Link between termination and outcome in psychotherapy

Overall there is a lack of literature devoted to this topic, in which a specific relationship between the quantity, and/or the nature of termination activity and client outcome is explored. Quintana & Holahan (1992) found that termination activity was strongly associated with level of client outcome, measured using a counselling outcome questionnaire. Termination of unsuccessful cases being characterised by less review of the course of counselling, fewer attempts to bring closure to the counsellor-client relationship, and more limited discussion of clients' feelings about ending counselling. There was no significant difference between successful and unsuccessful cases in planning for the future. The authors speculate that the reduced termination activity in unsuccessful cases may be due to a reluctance to discuss uncomfortable

material, such as reviewing how useful therapy has been. There was greater discussion of clients' affective reactions to termination when these were positive and no more discussion of clients' negative feelings in unsuccessful cases than in successful cases. One of the important drawbacks with this study is the difficulty in assuming causality between termination activity and outcome.

1.5.3 Therapist responses to termination

There is relatively little literature in acknowledgment of how the therapist responds personally to termination. Penn (1990) highlights the importance of therapists being aware of their own feelings during the termination process;

'They, too, have been part of an intense and significant relationship that is ending prematurely. They must leave patients they care about and know they cannot continue a relationship with them or hear what happens in their lives....anxiety over the separation, sadness over the losses ... are all reactions understandably triggered by the situation'. (Penn, 1990, p.381).

Martin & Schurtman (1985) define 'termination anxiety' on behalf of the therapist as a distinct and universal phenomenon. They suggest that it can interfere with therapy; the therapist may try to avoid addressing termination, deny their own importance to the patient, fail to terminate, do so abruptly, or allow the patient to deny their feelings about ending psychotherapy.

1.5.4 Summary

Techniques and strategies for facilitating the termination phase in psychotherapy have come from a counselling perspective. These involve discussion of the end of therapy; reviewing the course of therapy; gaining closure in the therapeutic relationship; and discussing the patient's future plans. Termination activity from this perspective has been strongly correlated with outcome in counselling psychotherapy although a causal

relationship cannot be assumed. Therapists' personal responses to termination may contribute to the way in which they manage the termination phase with their patients.

Having outlined some of the theory and research relevant to the study of termination in therapy, in the following sections 1.6 and 1.7 two different types of therapy, Interpersonal Psychotherapy and Cognitive Behaviour Therapy, are described, including their respective handling of the end of therapy.

1.6 Interpersonal Psychotherapy

1.6.1 Introduction

Interpersonal psychotherapy focuses on the social functioning of individuals and seeks to facilitate therapeutic change by helping patients to modify or develop their relationships with other people. It is a time limited, here and now focused treatment and has been found to be an effective intervention for client groups with various psychiatric disorders (Mufson, Moreau, Weissman & Klerman, 1993; Rossello & Bernal, 1999; Stuart & O'Hara, 1995a).

Adolf Meyer and Harry Stack Sullivan were psychiatrists working in a climate of traditional medical and psychoanalytic approaches to psychiatric disorder in the 1950s. Sullivan became interested in the immediate person to person involvement of the patient with others, in place of a traditional emphasis, medical and psychoanalytic, on the internal world of the depressed person in isolation from other people (Weissman, Markowitz & Klerman, 2000). These ideas were extremely influential in the development of IPT, by Gerald Klerman and Myrna Weissman, who wrote their first description of the approach in 1984. At this time the main purpose of operationalising the interpersonal approach to psychotherapy was for its inclusion in The National Institute of Mental

Health Treatment of Depression Collaborative Research Program (Elkin et al., 1989), a large multi-centre trial investigating the effectiveness of a variety of treatments for depression.

1.6.2 Theory

The theoretical emphasis that IPT places on social factors in the understanding of depression, is based on the well established phenomenon that social support is a protective factor in the development and maintenance of psychological disorders (Cobb, 1976; Cohen & Wills, 1985). Social support has been suggested as both preventative of depression, and a mediator between the experience of life events and depression (Paykel, 2001). In Brown & Harris' 1978 study, a lack of social support was found to be one of four major vulnerability factors in predicting the onset of depression in individuals facing a major life event. These findings were incorporated into a socio-cognitive model of depression by Champion & Power (1995), who suggested that a lack of social support reduces an individual's potential roles and goals in life, and constrains their options for flexibility in engaging in self-value increasing activities once depressed. Consequently IPT is grounded in theory based on empirical research, that a person's psychological well being is effected by their current relationships with other people. IPT acknowledges the importance of attachment theory in the development of early relationships, although does not directly address difficulties in past relationships as a focus of therapy.

1.6.3 Practice

IPT has a dual focus in that it aims to treat the symptoms of depression and also to address current difficulties in relationships. In the initial phase of treatment a diagnosis of depression is established by reviewing symptoms and the patient is given the 'sick role'

(Weissman et al., 2000, p.44). The sick role defines the patient as in need of help and informs the patient of the obligation to cooperate in getting well and giving up the sick role as soon as possible.

The interpersonal inventory involves reviewing the development and maintenance of current and past relationships. It is a way of relating depression to the social context for the patient. One of the main reasons for this is to determine which interpersonal difficulties are most central to the patient's current depression, which will subsequently be the main focus of psychotherapy.

IPT divides interpersonal difficulties into four different types; 1) grief; 2) role transition; 3) interpersonal role disputes; 4) and interpersonal deficits/sensitivities. The purpose is to identify the most recent stresses the patient is trying to cope with, and to agree with the patient on which area is most problematic.

Having established the most important area to focus on, the intermediate phase of therapy involves helping the patient discuss aspects of the interpersonal difficulty identified; being aware of the patient's emotional state and the therapeutic relationship; and facilitating the patient's use of treatment.

1.6.4 Termination

In IPT the termination phase of psychotherapy is defined as a distinct phase of therapy. This phase is the focus of the last 2-4 sessions of treatment. There is a belief that a failure to deal adequately with termination may lead to a premature return of symptoms. Interpersonal Psychotherapy identifies 'tasks of termination' (Weissman et al., 2000).

1) discuss with the patient that the end of psychotherapy is approaching and to elicit their reaction to this;

2) acknowledge that this can be a time of potential grieving and may raise negative emotions;

3) encourage the patient to recognize their own independent competence from the changes they have made during psychotherapy and to consider their future coping realistically. This can be understood in terms of relapse prevention.

Overall an emphasis is placed on the positive aspect of ending, including acknowledging skills and understanding gained. In particular reviewing changes and successes in the patient's interpersonal network is considered vital during termination. During termination the patient reviews and evaluates treatment by repeating earlier measures of mood and interpersonal functioning. The patient is encouraged to think about what psychotherapy did not achieve. Weissman et al., (2000) draw attention to providing the patient with a sense of ownership of the changes that have been made, particularly if the patient has tended to credit the therapist for their support and guidance as being central to improvements made.

Miller et al., (1994) describe IPT for late life depression, following the loss of a spouse. Six case studies were briefly described and it was from these that comments regarding the specific importance of termination issues in grief focused IPT were derived. It is concluded that when the focus is grief, from the beginning the number of sessions should be clearly stated; there should be open discussion of the possibility of a resurgence of symptoms during termination; new relationships should be encouraged; and there should be a focus on alternative coping strategies, such as coping with loneliness.

The authors comment that the reduced focus during IPT on the parallels between past relationships (e.g. with parental figures) and the therapeutic relationship itself, decreases the intensity of patient-therapist termination issues.

1.7 Cognitive Behaviour Therapy

1.7.1 Introduction

Cognitive Behaviour Therapy (CBT) emphasises the importance of how an individual interprets experiences, and how this affects their thoughts, feelings and behaviours. It is an active, structured, problem – focused and time-limited approach to therapy. It is based on the premise that psychological difficulties are maintained by negatively biased information processing and associated dysfunctional beliefs (Beck, Rush, Shaw, & Emery, 1979; Butler & Beck, 1995).

Beck (1963) originally described depression as a form of thought disorder, whereby the individual distorts incoming information in a negative way. He developed cognitive therapy (CT) to help an individual identify and modify their ‘thinking errors’ and dysfunctional thought processes. The inclusion of a behavioural component, whereby patients are taught to modify their behaviour as a means of modifying their thoughts and feelings, has led to the terms ‘cognitive therapy’ and ‘cognitive behaviour therapy’ being used interchangeably.

1.7.2 Theory

Cognitive behaviour therapy is based on four basic assumptions of the cognitive model (Clark & Steer, 1996):

1. Individuals actively construct their reality (Beck, 1967)

All personal experiences are the product of an information processing system that selects, filters and interprets environmental stimuli. Individuals attach different personal meaning to events that happen, which lead to a range of different emotional or behavioural responses (Beck, 1991). Depressed individuals tend to interpret personally significant negative experiences as supporting their beliefs about being a failure.

2. Cognition mediates affect and behaviour (Beck, 1991)

This assumption refers to the role that thinking plays in psychological disorders, such as depression. Rather than being causal, the model suggests that cognition (thinking), emotion and behaviour are interactive constructs. As a result thought processes do not cause depression single handedly, but play a crucial role in maintaining the disorder. This allows for the inclusion of the behavioural component of therapy, as another means of intervention.

3. Cognition is knowable and accessible

This refers to the fact that problematic thoughts are accessed, however automatic, instinctive or spontaneous they may be. The cognitive model assumes that the individual in therapy can be trained to gain access to the products of their faulty information processing (Beck, 1991).

4. Cognitive change is central to the human change process

Clark & Steer (1996) argue that this assumption is the cornerstone of cognitive therapy and its ability to successfully treat psychological disorders such as depression. The argument is that emotional and behavioural improvement is only likely to happen if the mediating products – thought processes – change. Broadly

speaking this is achieved directly by challenging thoughts and beliefs, or indirectly by modifying behaviour. The cognitive model views behavioural interventions as being successful due to the impact they have on cognitive processes, as opposed to directly mediating emotional change, although this has been re-considered (Power & Schmidt, 2004)

1.7.3 Practice

In practice, cognitive therapy teaches patients to identify and monitor negative automatic thoughts about themselves, their future and the world. It helps patients to make an association between their thoughts, feelings, physiology and behaviour. Cognitions are evaluated initially in session with the therapist and eventually the patient learns to do so independently. The aim of therapy is to enable the patient to develop a more adaptive way of thinking, by evaluating the utility of current problematic cognitions (Butler & Beck, 1995). As therapy progresses patients learn to identify, evaluate and modify underlying dysfunctional assumptions that may have led them to develop depressive symptoms. Cognitive therapy also teaches behavioural interventions such as activity scheduling, self monitoring of mastery and pleasure and graded task assignment (Beck et al., 1979).

1.7.4 Termination

There is a relative absence of literature devoted to the ending of the therapeutic relationship in CBT, in contrast to literature exploring the establishment of this relationship (Andrusyna, Tang, Derubeis & Luborsky, 2001; Krupnick, Sotsky, Simmens & Moyer, 1992). Literature on the ending phase of CBT describes the focus of the last

few sessions of therapy as being one of relapse prevention and maintaining gains that have been made during therapy (Hawton, Salkovskis, Kirk & Clark, 1989).

'Before treatment ends it helps to draw up a plan for the future, or 'blueprint', specifying how to handle future difficulties...this should list all the strategies that were useful...such as keeping thought records and relaxation exercises' (Hawton et al., p 125).

This involves reviewing therapy and encouraging the patient to think about how in the future they might use what they have learned to prevent psychological distress. There is an emphasis on the patient explicitly thinking about what would be the early warning signs of a deterioration in mental health, so that they might put preventative techniques into practice. To facilitate the patient developing confidence to cope with their problems independently, the therapist becomes less directive towards the end of treatment and usually spaces sessions out more towards the end (Hawton et al, 1989).

Continuation Phase Cognitive Therapy (C-CT) focuses specifically on relapse prevention and is designed to follow on from a period of standard cognitive therapy (Jarrett, Kraft, Doyle, Foster, Eaves & Silver, 2001). The purpose of C-CT is to review strategies associated with effective symptom reduction, maintain skills acquired during standard cognitive therapy and develop coping strategies in preparation for identified or anticipated vulnerabilities. The authors suggest that to reduce residual symptoms and relapse, C-CT should be 'standard practice in cognitive therapy when acute phase remission is unstable'. The resulting implication is that cognitive therapy, without such an explicit focus on relapse prevention, is not as successful in maintaining symptom reduction as C-CT.

Schema focused therapy is an elaboration of the basic cognitive model described by Beck (1967). It explicitly targets the early maladaptive cognitive structures that can lead to

psychological distress in later life. These tend to be early and maladaptive beliefs such as 'I am unlovable' or 'I am weak' (Young, Klosko & Weishaar, 2003). By addressing underlying schema, therapy has a longer term preventative function in terms of symptom relapse when therapy has ended (Hawton et al., 1989).

Cognitive therapy focuses on a person's thinking, much more so than other therapies in which the therapeutic relationship may be held more central to the process of therapy. However this is not to say that the therapist is not alert to how the patient feels about ending therapy. Hawton et al., (1989) suggest that:

'worries about ending therapy are dealt with in the same way as other upsetting cognitions. It is important to encourage the patient to express them and to evaluate the evidence for their validity' (p.207).

The Center for Cognitive Therapy, based in the University of Pennsylvania, on their website 'strongly recommend that the final session be planned' (Center for Cognitive Therapy, University of Pennsylvania). They suggest that it is beneficial for the patient to review the work that has been done in therapy and 'say goodbye'. This is recommended rather than being stated as a fundamental task of termination.

CBT offers patients several follow up, or 'booster' sessions once therapy has ended. It is thought that these function to keep the patient motivated after therapy has ended (Hawton et al., 1989). However follow up sessions might also reduce the impact of termination, for both patient and therapist, as previous literature has suggested (Kramer, 1986; Marx & Gelso, 1987; Quintana & Holahan, 1992).

1.7.5 Summary of IPT and CBT

IPT and CBT are time limited, here and now focused psychotherapies that have been proven to be efficacious in the treatment of psychological disorders such as depression and anxiety. They differ however in their focus; IPT works with a patient on

understanding their current relationships and developing their interpersonal skills, whereas CBT focuses on the identification and adaptation of problematic thoughts and behaviours, in relationship to the maintenance of psychological problems. In line with the focus on relationships, IPT identifies the termination phase of therapy as a discrete phase and describes specific aims of this phase, in terms of ending the therapeutic relationship and facilitating the patient's disengagement from the therapeutic process. In contrast CBT places a relatively reduced focus on this phase of therapy and tasks identified are largely in terms of relapse prevention and the maintenance of gains made during therapy. The principle aim of the current study is to explore this observation further, in terms of clinical practice and the process of termination.

1.8 Summary of introduction

Psychotherapies in the NHS are used to alleviate symptoms associated with psychological distress. All psychotherapeutic interventions are based on the establishment of a therapeutic relationship between patient and therapist. Whilst an extensive body of literature exists examining the development of the therapeutic relationship, or alliance, there is a relative lack of literature exploring what happens when this relationship ends; the termination phase of psychotherapy. An exploration of the literature on a theoretical perspective of termination in psychotherapy has found it to be predominantly from a psychodynamic and psychoanalytic perspective. In the literature termination in psychotherapy has been understood as a time of sadness and loss, evoking a range of uncomfortable feelings. This was linked to literature exploring the impact of the ending of relationships in general; the therapeutic relationship being a relationship that will inevitably end. Empirical research on termination explores the wider range of

reactions to the end of psychotherapy. Techniques and strategies have been devised to enable the therapist to facilitate the end of the therapeutic relationship and termination activity has been linked with outcome in psychotherapy. A greater amount of termination activity has been found in more successful therapy cases. In this study the termination phase is considered in the context of two different psychological therapies widely used in the National Health Service; Cognitive Behaviour Therapy (CBT) and Interpersonal Psychotherapy (IPT). Whilst CBT does not explicitly recognise the ending of therapy as a phase, in IPT it is considered important and various tasks of termination are defined.

1.9 Aims and Hypotheses

Aims

1. To investigate how cognitive behaviour therapy (CBT) and interpersonal psychotherapy (IPT) differ in terms of total termination activity during final sessions of therapy.
2. To investigate more specifically how CBT and IPT differ in terms of termination activity during final sessions of therapy.
3. To investigate the relationship between termination activity and measured change of anxiety and depression.

Hypotheses

1. The first hypothesis predicted IPT would have greater total termination activity than CBT during final sessions of therapy.
2. The second hypothesis predicted that there would be a difference in terms of specific termination activity during final sessions of CBT and IPT. More specifically in IPT there would be greater activity regarding: discussion of the end

of therapy; closure of the therapeutic relationship; evaluation of therapy; discussion of the patients plans for the future; and patient expression of affect regarding the end of therapy, in comparison with CBT.

3. The third hypothesis predicted that there would be a positive correlation between termination activity and a reduction in symptoms of anxiety and depression.

2. Method

2.1 Background and preparation

The current study was undertaken as a result of the researcher's interest in aspects of the therapeutic process. This interest developed during clinical psychology training, as a result of exposure to different therapeutic models of working with patients. It became apparent that termination was an aspect of the therapeutic process that was relatively absent from the teaching and clinical supervision of certain psychological models of therapy, nonetheless it was experienced as a potentially difficult time for both patient and therapist during clinical work on placement. This led the researcher to question how termination is managed by therapists during their routine clinical work.

Prior to undertaking the study a proposal was approved by members of the training course staff, October 2005 (appendix 1).

Ethical Approval

Ethical approval was sought, and passed, from a research ethics subcommittee for psychiatry and clinical psychology, for a study carried out in 1999 investigating the outcome of brief structured psychotherapies for neurotic disorders in the National Health Service (appendix 2). The current investigation was carried out as an extension of this study, in which informed consent was obtained and data collected during that time.

Power analysis

A power analysis was performed in relation to the design of the study. It was found that for a between subjects t-test, with a large effect size ($d=0.8$), a one-tailed test and an alpha level of 0.05, to achieve power of 0.80, 20 participants would be needed in each therapy group (Clark-Carter, 2004).

2.2 Design

Data were gathered as part of a randomised controlled trial comparing brief structured psychotherapies for neurotic disorders in Primary Care. (The trial compared CBT and IPT and treatment as usual to evaluate the effectiveness of these interventions). The current study used a between subjects design to examine the differences between termination activity in the final (or penultimate) taped sessions of CBT and IPT. The content of communication in tape-recorded therapy sessions was analysed and coded according to a measure of termination activity. A correlational design was used to examine the relationship between termination activity in the final (or penultimate) sessions of CBT and IPT and outcome of therapy, as measured by change in score on an anxiety and depression questionnaire. The main dependent variable measured was termination activity. The main independent variable was type of psychological therapy. The content of communication in tape-recorded therapy sessions was analysed and coded according to a coding scheme based on the Termination Behaviour Checklist – therapist (TBC-T) (Quintana & Holahan, 1992). A qualitative component was incorporated in the study to illustrate findings in more detail.

2.3 Background to current study

Participants were recruited for an investigation of brief structured psychotherapies for neurotic disorders in primary care, the results of which are still being analysed. The study was a comparison trial of CBT, IPT and treatment as usual at early and late intervention. The aim was to compare the two psychotherapies, and specifically to compare early treatment intervention with delayed treatment intervention. Outcomes of therapies were

assessed in terms of symptom reduction, maintenance of change, subsequent use of health service and social and work functioning.

Participants

Participants were recruited by direct referral from a mixture of rural and city centre GP practices. Two hundred and eighty eight participants were referred in total. Participants were assessed by research psychologists, to establish diagnostic status and symptom severity. Participants were either diagnosed with Major Depression or an Anxiety Disorder. Forty two (14.2%) participants did not attend the assessment appointment, 70 (24%) did not meet inclusion criteria and 19 (6.5%) were withdrawn, either by themselves or by their GP following allocation. One hundred and fifty seven (54.5%) were allocated a place in the study. Participants were then randomly allocated to a treatment group; 65 underwent CBT; 64 underwent IPT; and 28 routine GP care (treatment as usual - TAU).

Sixteen therapists took part in the study; 9 provided CBT and 7 provided IPT. No therapist conducted both forms of therapy. The therapists were 4 clinical psychologists, 5 research psychologists, 3 psychiatrists, 1 nurse therapist and 4 community psychiatric nurses. In order to monitor the equivalent provision of individual therapies, all therapists were trained to an acceptable level on accredited training courses, and supervised by experienced clinicians during the investigation to monitor the adequate and equivalent provision of psychotherapy.

Procedure

Following assessment, participants were randomly assigned to one of five treatment options following the initial assessment: early intervention IPT, late intervention IPT,

early intervention CBT, late intervention CBT and routine GP care (treatment as usual; TAU). All psychotherapy treatment intervention groups were offered 12 or 16 weekly sessions. If the participant had a diagnosis of Major Depression, then he/she was offered a further 4 weekly sessions, whereas these extra sessions were optional for participants with an Anxiety Disorder. At the end of the 12 or 16 sessions, participants were offered a further 3 optional follow up sessions over a 6 month period. All therapy sessions were tape recorded in order to provide some qualitative data, for further research and teaching purposes and to assess for reliability of the therapeutic intervention provided.

A range of assessment measures were completed at four stages during the investigation, as a measure of the effectiveness of the intervention. Measures were completed when referred (baseline); at the start of therapy; at the end of therapy; and at a month's follow up session.

Initial results and conclusions

Outcome data are currently being analysed by the research team for the study.

2.4 Research strategy of the current investigation

The central intention of the current investigation was to compare what happens during the ending of two different psychotherapies. This was decided best accomplished by a content analysis of tape recorded, final therapy sessions. Content analysis deals with communication content as the primary subject of investigation and essentially aims to make qualitative data quantifiable. It was decided that this would be an appropriate approach to take in order to make a statistical comparison between CBT and IPT on various components of termination.

The strength of content analysis as a research method is that it endeavours to fit the scientific paradigm of social research. For example all decisions on variables, categories, their measurement and coding rules are made before the content is analysed. In this respect the approach differs from a purely qualitative approach such as grounded theory in which the researcher generates categories to fit the data (Bryman & Burgess, 1994). There is an emphasis on reliability of the process as will be described in more detail in section 2.8. The investigation is hypothesis-driven and the aim is for findings to be representative and generalisable.

'Content analysis is a research technique for making replicable and valid inferences from data to their context' (Krippendorff, 1980 p 12).

However the approach simultaneously facilitates handling of some of the intricacies and subtleties of the therapeutic process, by ascribing a quantitative component to what are essentially the qualitative, narrative aspects of communication.

2.5 Data

Data were analysed as part of the investigation of brief structured psychotherapies for neurotic disorders in primary care described in section 2.3, in which all sessions were tape recorded. Final taped sessions of CBT and IPT were identified to be included in the sample for the current study which will be discussed in the following section.

2.5.1 Sample

Of the original sample of 157 participants, 112 participants were allocated to a therapy group (64 CBT; 48 IPT). Of these participants 21 CBT participants and 27 IPT participants completed the course of therapy for which tapes were available (either 16 or 12 sessions). Tapes were included if they were of good enough sound quality to hear accurately; and were complete sessions (i.e. not interrupted half way through). Where a

final session (session 12 or 16 respectively) was not available (due to the above inclusion criteria), the penultimate session was identified in its place (session 11 or 15).

A sample of 11 final (session 16); and 5 penultimate (session 15) taped CBT sessions; and 23 final (22 session 16; 1 session 12); and 3 penultimate (session 15) taped IPT sessions were selected for inclusion in the study. Altogether 16 CBT and 26 IPT sessions were selected for analysis. This represents 37.5% of patients allocated to a therapy group. A database was created to record each taped therapy session analysed. Relevant corresponding patient demographic information was also included on the database; patient name, name of therapist, sex, age, type of therapy and number of therapy session recorded.

2.6 Materials

2.6.1 Technical material

A Marantz portable cassette recorder (PMD201) was used to listen to taped therapy sessions and transcription of relevant sections was made using pen and paper. A database was created using Microsoft Office Excel (2003) to record demographic information identifying tapes that had been analysed. The statistical package SPSS for windows version 13.0 (SPSS Inc., 2006-2007) was used for the analysis of data.

2.6.2 Termination Behaviour Checklist – Therapist (TBC-T) (appendix 3a)

The current study used a coding scheme derived from the Termination Behaviour Checklist- Therapist (Quintana & Holahan, 1992). The coding scheme is described in detail in section 2.7.1. and was developed as part of an initial pilot study process described in section 2.7 (appendix 4 for a copy of the coding scheme).

The TBC-T is based on the Termination Behaviour Checklist (TBC) developed by Marx & Gelso (1987) (appendix 3b). Items for the TBC were generated from a review of the termination literature and refined by a panel of experts on termination. Test stability of TBC was estimated with test-retest (1 week) correlation ($r=.88$, $p<.05$). The original TBC contains 17 items that describe various actions that occur during the ending phase of therapy.

The TBC-T was adapted by Quintana & Holahan (1992) to be used by therapists, as opposed to patients. Various changes were made to the checklist, resulting in 21 new items being added. The TBC-T includes 38 items.

Items were sub-grouped into a number of categories that were consistent with previously reviewed components of termination; discussion of the end of therapy, review of therapy and goal attainment, discussion of plans for the future (after therapy), closure in the therapist-patient relationship, patient expression of affect about the end of therapy, and problematic termination reactions. These categories were created by two independent raters, using specific descriptions that included excerpts from the literature of these termination components and classified items into the six categories with 92.1% agreement (Quintana & Holahan, 1992, p.301).

The stability of all the TBC-T items was estimated across time (Quintana & Holahan, 1992). Using the sum of all items, the 3-week test-retest Pearson product moment correlation was .89. Of the 38 items, 33 (86.8%) satisfied the phi correlation coefficient criterion ($p<.01$) used by Marx & Gelso (1987).

The TBC-T was designed to be completed by the therapist, categorically indicating yes or no, as to whether the particular item of termination behaviour occurred or did not occur

during the termination phase of therapy (ie last few sessions). It was selected for the current study as the only measure of termination activity available. It was also not specific to either CBT or IPT (as the types of therapy being investigated).

2.6.3 Coding scheme and coding rules

A coding scheme (appendix 4) was used to code transcribed data. Coding rules (appendix 5) were described to facilitate equivalent, reliable coding of data into the categories of the coding scheme. The process of developing the coding scheme and the process of coding is described in section 2.7.

2.6.4 Outcome measures

Of the outcome measures used in the original study, scores from the Beck Depression Inventory (BDI-II) and the Hospital Anxiety and Depression Scale (HADS) were used as measures of depression and anxiety in the current study. They were selected as they are both widely used and recognised measures of anxiety and depression.

Beck Depression Inventory (BDI-II) (appendix 6a)

The Beck Depression Inventory is a 21-question multiple choice questionnaire that is widely used for measuring the severity of depression. It is composed of items relating to symptoms of depression, such as hopelessness and irritability, feelings of being punished, as well as physical symptoms such as fatigue, weight loss, and lack of interest in sex. The original version (Beck, Ward, Mendelson et al., 1961) was revised to coincide with the updated Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for depression (American Psychiatric Association, 1994). In the BDI-II participants are asked to rate how they have been feeling for the past two weeks.

Each of the 21 questions on the BDI-II are scored on a scale value of 0 to 3. The questionnaire score provides a measure of degree of severity of depression: 0-13 – minimal depression; 14-19 – mild depression; 20-28 – moderate depression; and 29-63 – severe depression. The BDI-II has good internal consistency, with a Cronbach's alpha coefficient of 0.85 (Ambrosini, Metz, Bianchi, Rabinovich & Undie, 1991).

Hospital Anxiety and Depression Scale (HADS) (see appendix 6b)

The Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983) was developed to provide a simple and reliable tool for use in medical practice. The HADS has been widely used in community and primary care settings. In a review of its validity, Herrmann (1997) concludes it yields clinically useful and meaningful results as a psychological screening tool. The internal consistency of items in each of the subscales is good. Cronbach's alpha correlation coefficients are around .80 to .93 for anxiety and .81 to .91 for depression (Herrmann, 1997).

The questionnaire is composed of fourteen items; seven questions relating to anxiety and seven relating to depression. Responses are scored on a four point scale (0-3) and therefore possible scores range from 0-21 for both anxiety and depression. The HADS provides an indication that a patient probably has clinically significant levels of anxiety or depression, rather than producing a definite diagnosis. Zigmond and Snaith (1983) provide what are now generally accepted cut-off scores for both subscales: 7/8 for possible and 10/11 for probable anxiety or depression.

2.7 Procedure

2.7.1 Pilot study

Prior to establishing a complete list of categories to be used to classify passages of transcribed text, the researcher became familiar with the content of the CBT and IPT final sessions. The purpose at this stage was to informally assess the face validity of the TBC-T and its applicability to the content of the material. This involved the researcher listening to a small sample of tapes (6) and transcribing by hand, sections of the therapy session which in the researcher's opinion, related to termination. To describe this more specifically, when comments were made about this being 'the last session' or 'the end of therapy', the paragraph was recorded. The number at which the counter on the tape recorder had reached was also recorded. The researcher also broadly recorded any aspect of the communication content that could be arguably related to the end of therapy. This was based on the literature reviewed, behaviour components described in the TBC-T and also inevitably related to the researcher's own understanding of termination, based on clinical work as a trainee clinical psychologist (Chenail & Maione, 1997).

It was during this process that the researcher became aware of an additional category and additional items within several categories, to be included in the coding scheme that had not been included in the original TBC-T. The additional category and items were verified, as to their appropriateness, with two experienced clinicians and are described in the following section on the coding scheme.

2.7.2 Coding scheme (appendix 4)

In the current investigation the concept of termination was broken down into a number of behavioural categories based on the TBC-T (Quintana & Holahan, 1992). Six categories

(and an additional category included as a result of the pilot study process) were broadly taken as the main categories into which the content of the therapy session was coded;

1. Discussion of the end of therapy
2. Evaluation of therapy
3. Closure of the therapeutic relationship
4. Discussion of plans for the future
5. Patient expression of affect about the end of therapy
6. Implicit reference to the end of therapy (additional category)
7. Problematic termination reactions.

Each category was comprised of several items. These were based on the TBC-T and the outcome of the pilot study. The following section provides a more detailed explanation of each category and the items within each category. In each category an item 'other' was included to describe any comment that was observed as relevant to the category but not to any of the items defined in that category.

1. Discussion of the end of therapy

In the TBC-T this referred to how the date of the final therapy session was reached, whether this was a mutual decision or externally imposed. In the present study these subcategories became redundant as the nature of the study dictated that from the outset an agreed number of sessions – 12 or 16 – would be offered.

This category refers broadly to the way in which the end of therapy is discussed. It requires the coder to make a judgment as to: the significance of the end of therapy; whether ending therapy was used to process the patient's experience of loss; and whether the patient wanted to extend therapy further. Two additional items were included to

indicate when the end of therapy was mentioned: 'therapist mentioned ending'; 'patient mentioned ending'.

2. Evaluation of therapy

This category refers to how the therapist and patient perceive the sessions to have progressed. More specifically whether the therapist summarises the work (including changes noticed in the patient and what the therapist perceives the patient to have learned); whether patient and therapist jointly assess the extent to which goals in therapy have been attained; whether the patient states things he/she likes/dislikes about therapy; and whether the patient asks questions about how therapy works. An additional item was included referring to whether the patient summarises the work (including changes made or noticed; what they have learned; what they have found useful/helpful or not useful/helpful).

3. Closure in the therapist-patient relationship

This category refers specifically to behaviours that mark the end of therapy; including the patient thanking the therapist; therapist sharing feelings about therapy; patient asking personal questions about the therapist; and patient giving a gift to the therapist. Two additional items were included; therapist thanking patient; and patient wanting to mark the end of therapy. Three items from the TBC-T were excluded due to them being either relative measures that would require the researcher to have listened to earlier sessions – therapist talking more about self; and therapist and patient relating more like equals; or being unobservable – therapist hugged or shook hands with the patient.

4. Discussion of plans for the future

This category refers to discussion between patient and therapist regarding any future plans. Items include therapist suggesting other types of help for the patient; whether the patient wants an opportunity for further contact with the therapist; or expresses plans to receive further therapy in the future. Additional items were included regarding discussion of relapse prevention and maintenance of perceived gains, whether initiated by the therapist; or whether a comment made by the patient regarding future relapse / relapse prevention. An item on the original TBC-T was excluded 'therapist inviting the patient to return to therapy'.

5. Patient expression of affect about the end of therapy

This category refers to whether the patient expresses feelings regarding the end of therapy and provides items for a range of emotions e.g. 'calmness', 'concern', 'pride', 'frustration', 'fear' and 'other'; whether the patient feels healthy; a sense of loss; or alone. Additional items were included for feeling hopeless; denying any feelings about the end of therapy; and whether the therapist facilitated the patient's expression of affect about the end of therapy.

6. Patient made implicit reference to the end of therapy

This is an additional category that was not originally included in the TBC-T. It refers to whether the patient describes an event or experience that arguably is thematically linked to the ending of the therapeutic relationship, and therefore implicitly, rather than explicitly, makes reference to the end of therapy. This is defined more specifically as whether the patient describes the loss of something or someone, their own mortality, or

the end of an important relationship (whether in the past, present or future); e.g. a patient talking about her ex husband (name changed):

‘I’ve got a photo of Alex, just a silly one, it used to make me feel better. Then the other day I took the picture down, decided I’m not looking at a picture of Alex everyday anymore. I don’t think it’s serving its purpose anymore, maybe I should have put it in the bucket!’

Or a further example of a patient describing the loss of a work related project:

‘I’ve been working on this for a few months now, and do feel I’m in danger of losing it if I don’t engage people more in the process...’

Whether the therapist acknowledges the reference and/or uses it to facilitate further discussion of the patient’s feelings about ending therapy is also coded; e.g. in response to the comment described about the patient’s ex husband Alex, the therapist replies:

‘Has the ending of therapy featured in the week for you? It seems like you’ve been quite reflective, looking at what you’re letting go...’

7. Problematic termination reactions

This category refers to whether behaviours identified as problematic, associated with the end of therapy in particular, were present including; the patient raising new problems; wanting to extend therapy (this item was also included in the category ‘discussion of the end of therapy’); devaluing therapy and/or the therapist; and idealising therapy and/or the therapist. An additional item was included for whether the patient expressed an exacerbation of existing or previous symptoms.

Coding rules were written to facilitate identification of termination relevant comments and the coding process (appendix 5). These were based on the descriptions of the items in the TBC-T.

2.7.3 Unit of data collection – transcription of termination relevant comments

Complete sessions were not transcribed due to the time required to do so. Instead the researcher listened to each taped session, with the coding scheme and coding rules to hand, and the task was to decide when either patient or therapist were talking about an item relevant to the coding scheme. At the start of each tape the tape counter was set to zero. Having identified a comment relevant to the coding scheme, the researcher stopped the tape and transcribed the paragraph of speech, using the number on the tape counter as identification. During the turn-taking of conversation each spoken sequence relevant to the coding scheme, before the other responded (patient or therapist), was defined as a unit of data collection. It was coded by the number shown on the tape recorder counter at the start of the spoken sequence and written next to each transcribed paragraph (see appendix 7 for example).

Originally carrying out some sort of time analysis was considered, for example of time spent on each termination activity', however this proved impractical given the considerable amount of material to be coded, and the wide variations in the length of activity. Identification of data to be transcribed was time consuming and required repeated listening and re listening to sections of the tape.

2.7.4 Coding process

Having transcribed termination relevant paragraphs of speech, data were ready for coding. Prior to coding the researcher read through the transcript of the session. Following this the researcher then ascribed each unit of data in the transcript, into an item (or items) of the coding scheme, by writing the number of the unit of data (based on the tape counter) in the appropriate item on the coding form (see appendix 8 for example).

An initial trial run of coding 3 sessions was carried out by the researcher. This process was repeated 3 times in each case and checked for consistency of coding.

Where possible only one code per data unit was applied. However each data unit could potentially be coded in different items of categories i.e. categories were therefore not exhaustive. The data units, as spoken paragraphs of varying size, potentially could be coded differently depending on what aspect of the paragraph was being considered. E.g. in the following short paragraph;

Therapist; 'It's our last session today, I was wondering how you felt about that?'

The unit can be categorised as 'therapist initiated discussion of the ending of therapy' (an item of the category 'discussion of the end of therapy') and also 'therapist facilitated the patient's expression of affect about ending therapy' (an item of the category 'patient expression of affect about the end of therapy').

Each data unit could not be repeatedly coded in the same item of a category. E.g. in the case of a longer paragraph, in which there might be more information;

Patient: 'I just feel that I've maybe learned to change the way that I think about things, I definitely am starting to realise that I don't always see things the way they are, and on top of that this has also given me the motivation to start making an effort staying in touch with friends.'

In this section the patient is evaluating some of the gains made in therapy. She states having learned how to change her thinking and also an increase in motivation to keep social contacts. Whilst these might be two separate gains, the unit would be coded as 'patient summarised the work' (see appendix 9 for examples of coding process).

This procedure was carried out for all sessions analysed. Completed coding form results displayed the frequency of the occurrence of particular termination behaviours, as defined

by the categories and items of termination behaviour. This information was then put into a database prior to statistical analysis.

2.8 Analysis of reliability

2.8.1 Inter rater reliability of identification of termination relevant comments

This was measured with respect to the selection of termination relevant material to be transcribed for coding. The researcher did this independently initially and then another trainee clinical psychologist was given a copy of the coding scheme, and coding rules prior to listening to two, one hour (approximately) final therapy sessions. During this process there was informal discussion about categories and the coding process. Following this simple percentage agreement (appendix 10) between the researcher and the rater, for identification of termination relevant comments was computed and is presented in results section 3.1.3 .

2.8.2 Inter rater reliability of coding process

In order to establish a measure of reliability of the coding process described, transcribed termination relevant comments, from 4 randomly selected therapy sessions (approximately 10% of total number of sessions analysed) were also coded by two trainee clinical psychologists. Prior to coding each were given a verbal explanation of the study by the researcher and a copy of the coding scheme. A copy of the coding rules was also given to each coder and the researcher gave the coders informal, verbal instructions on how to carry out the coding process. This was complimented with regular discussion between all coders during the coding process. The coders each completed the same coding forms as the researcher to enable analysis of the extent to which there was agreement between them for each variable. Following this a measure of simple

percentage agreement between the principal researcher and coder was computed for each of the seven categories (see results section 3.1.2). In order to compute percentage agreement, only those comments in which only one code had been applied were included in the reliability analysis.

2.8.3 Reliability of categories of termination

The original TBC-T (Quintana & Holahan, 1992) used a measure of inter rater reliability based on the classification of termination items by two independent judges, into categories with 92.1% agreement. A similar procedure was carried out in the present investigation. A clinical psychologist categorised randomly presented items on the coding scheme into each of the 7 categories and percentage agreement was computed (see results section 3.1.1).

3.Results

The results section covers a discussion of the reliability of the coding scheme, followed by quantitative findings and a commentary on qualitative aspects of the content of sessions analysed.

3.1 Reliability of the coding scheme

3.1.1 Reliability of categories of termination

Summary variables were computed from the sum of items in each of the seven categories of the coding scheme. An independent judge categorised randomly presented items of termination into the seven categories, with 90.4 % agreement with the categories of the coding scheme.

Cronbach's alpha was computed to assess the internal reliability of items within the seven categories of the coding scheme. Alpha should ideally be around .9 and never below .7 (Clark-Carter, 2004). The following table presents cronbach's alpha correlation coefficients for each category of the coding scheme:

Table 1 Results of cronbach's alpha internal reliability analysis

| Category of coding scheme | Cronbach's alpha correlation coefficient |
|-------------------------------------|--|
| Discussion of ending | .475 |
| Evaluation of therapy | .658 |
| Closure of therapeutic relationship | .607 |
| Discussion of future | .456 |
| Expression of affect | .679 |
| Implicit reference to ending | .448 |
| Problematic termination reaction | .517 |

Cronbach's alpha provides a perspective of how each of the items in the category relate to each other. Individual item-total correlation coefficients of items within a category are discussed in the following section and presented in appendix 11.

I. Discussion of the end of therapy

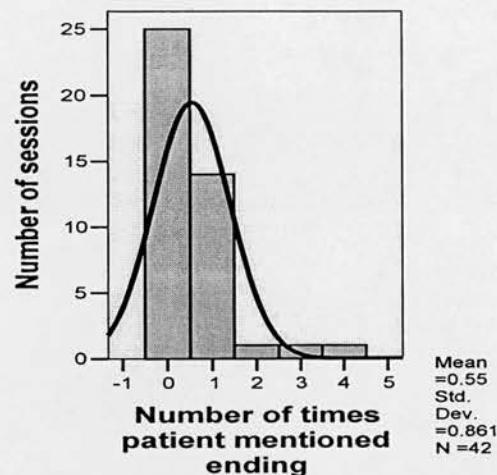
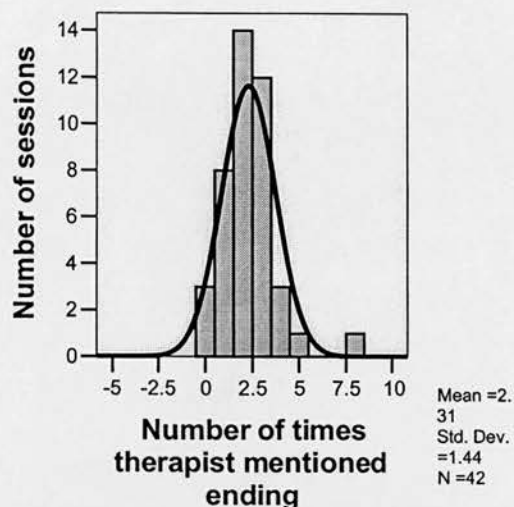
Table 2 showing the items in the category

| Item |
|-----------------------------------|
| Patient wanted to extend therapy |
| Therapist mentioned ending |
| Patient mentioned ending |
| Other |

(Items 'the end was a significant event', and 'the end was used to process the patient's experience of loss' were excluded from analysis of the scale as categorical items, requiring a yes/no response).

In this category the overall Cronbach's alpha of .475 is low. This may be due to there being only four items in the category, the minimum amount on which Cronbach's alpha can be computed. The item 'therapist mentioned ending' has the lowest correlation with other items (.158) and if removed from the category the overall Cronbach's alpha rises to .551. A histogram of each item (appendix 12), representing the frequency of comments made in each category, indicates that whilst the other items in the category are distributed with a positive skew, the item 'therapist mentioned ending' has a normal distribution. It was the most common item of the category.

The following histograms illustrate the number of times that the therapist mentioned ending in comparison to patient mentioned ending. The y axis represents the number of sessions in which the therapist / patient mentioned the ending that particular number of times.

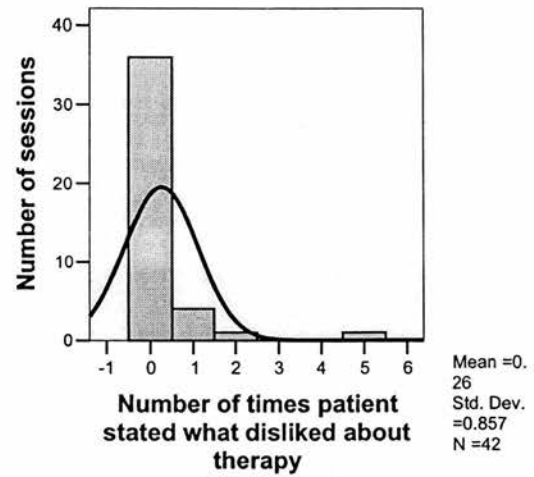
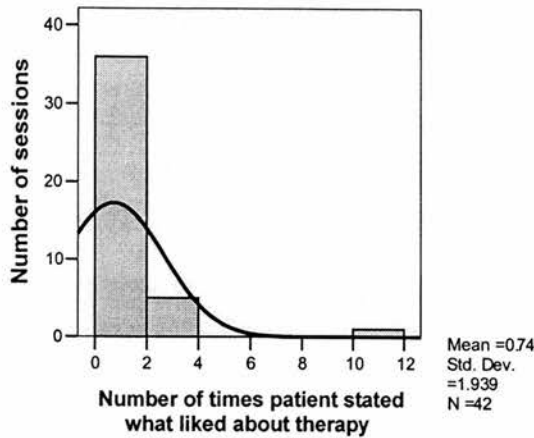


ii. Evaluation of therapy

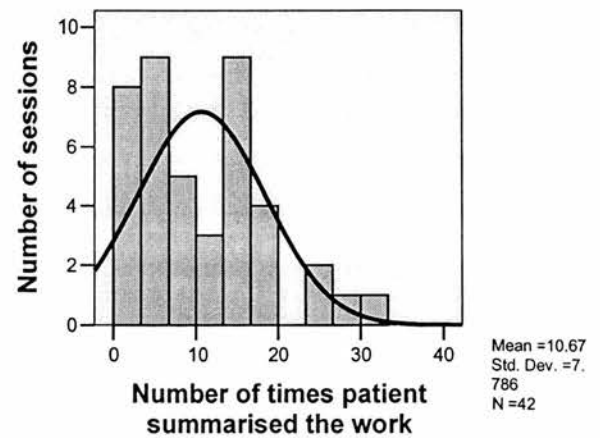
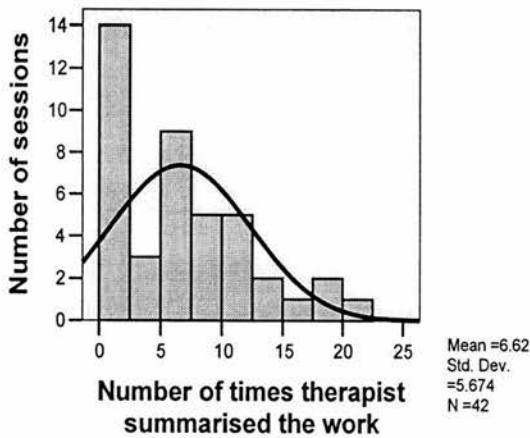
Table 3 showing items in the category

| Item |
|--|
| Therapist summarizes the work |
| Patient summarizes the work |
| Patient and therapist assessed goals |
| Patient stated things he /she liked about therapy |
| Patient stated things he/she disliked about therapy |
| Patient asked therapist questions about how therapy works |
| Other |

In this category the overall Cronbach's alpha correlation is .658. Items of the category that have the lowest item-total correlation are 'patient stated things he/she liked about therapy' and 'patient stated things he/she disliked about therapy' (-1.25 and -.80 respectively). A histogram of the distribution of data within each of the items indicates a low frequency count of data for both items. When both items are removed from the category, Cronbach's alpha increases to .733.



The relative prevalence of 'summarizing the work', (patient or therapist) in comparison to the previous items, is reflected in the following histograms:

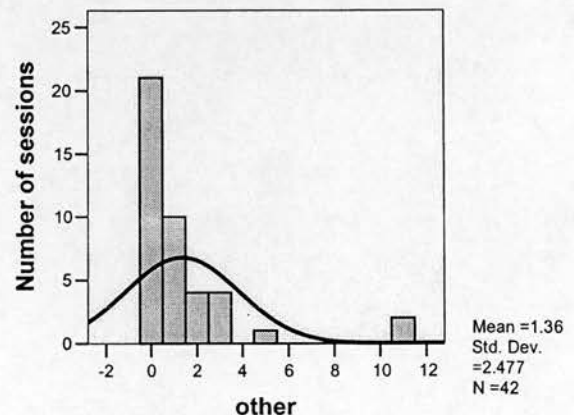
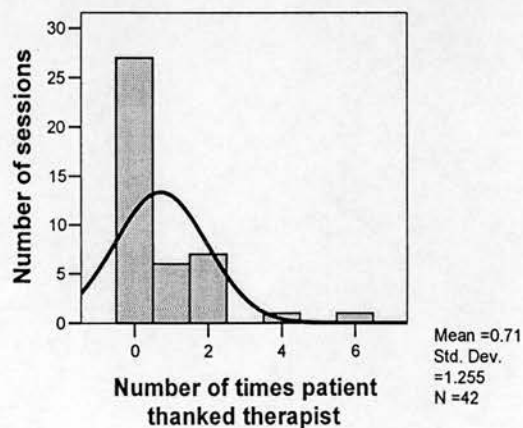


iii. Closure of the therapeutic relationship

Table 4 showing items in the category

| Items |
|--|
| Patient thanked therapist |
| Therapist thanked patient |
| Therapist shared feelings about therapy |
| Patient asked therapist personal questions |
| Patient gave therapist gift |
| Patient wanted to mark the end of therapy |
| Other |

In this category the overall alpha correlation of .607 rises to .624 if the item 'patient wanted to mark the end of therapy' is deleted (with a corrected item-total correlation of .000). A histogram of each item in the category (see appendix 12) indicates that across the sample there were no instances in which the item 'patient wanted to mark the end of therapy' was categorised. 'Patient thanked therapist' and the item 'other' were the most frequently observed items in the category. The following histograms illustrate their distribution:

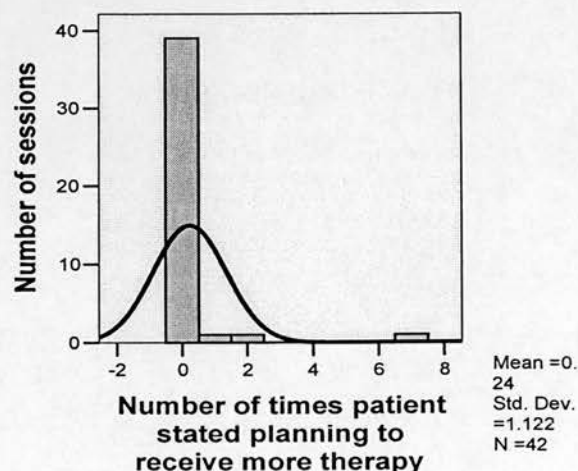
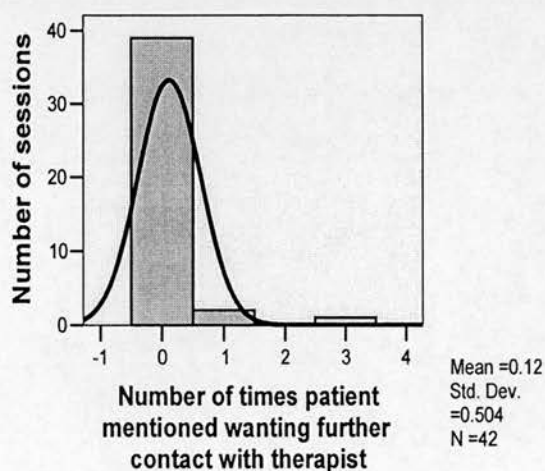


iv. Discussion of patient's plans for the future

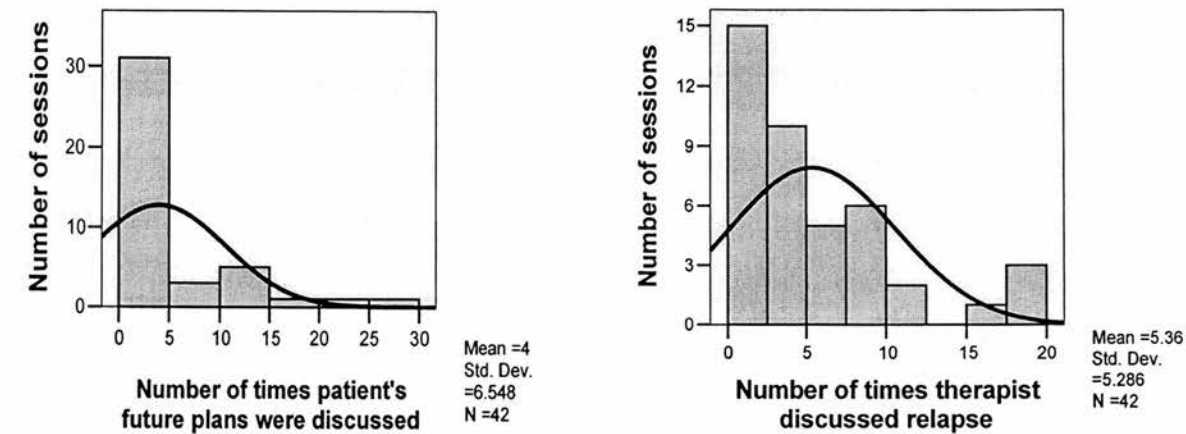
Table 5 showing items in the category

| Item |
|---|
| Discussed plans for the future |
| Therapist suggested other types of help |
| Patient wants further contact with therapist |
| Patient plans to receive more therapy |
| Therapist commented on relapse |
| Patient commented on relapse |
| Other |

In the category for discussion of the future, two items ('patient wants further contact with therapist' and 'patient plans to receive more therapy') have a corrected item-total correlation of -0.80 and -0.28 respectively. The overall Cronbach's alpha correlation of the category rises from .456 to .505 if both items are removed from the category. The following histograms illustrate the distribution of each of the items. Both highlight a small amount of data for each item, indicating its relative non occurrence in the sample.



In contrast ‘discussion of patient’s future plans’ and ‘therapist commented on future relapse’ were more frequently observed:

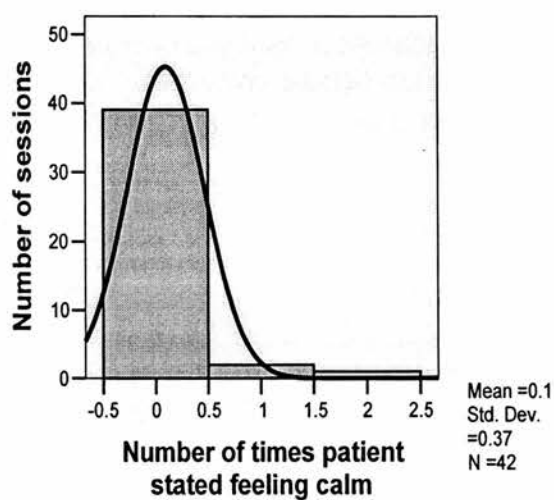


v. Expression of affect about the end of therapy

Table 6 showing items in the category

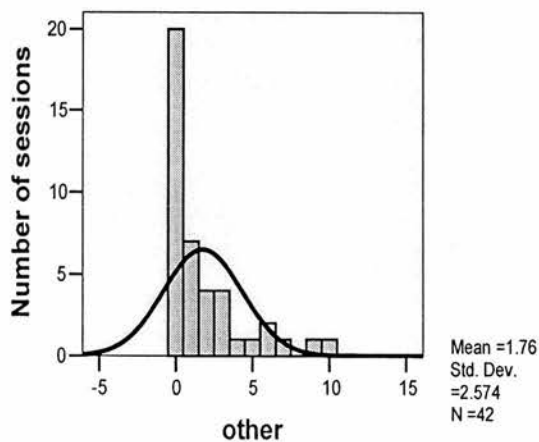
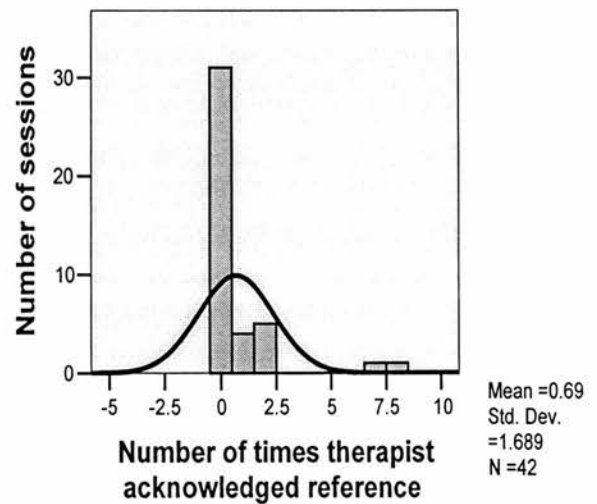
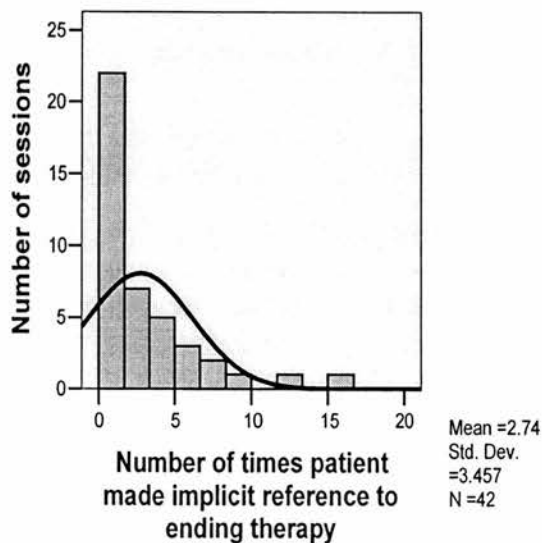
| Item |
|--|
| Expressed feelings |
| Healthy |
| Pride |
| Calm |
| Concern/worry |
| Frustration |
| Afraid |
| Loss/sadness |
| Alone |
| Hopeless |
| Denied feelings |
| Therapist facilitated expression of feelings |
| Other |

In the category of expression of affect about the end of therapy, 'calm' is the item with the lowest item total correlation. To delete this item from the category raises Cronbach's alpha of the category to .683. A frequency distribution of this item indicates that as an item, 'calm' was not frequently expressed by patients at the end of therapy.



vi. Patient made implicit reference to the end of therapy

Cronbach's alpha should not be computed on less than four items in a scale and therefore was not computed for the category 'patient made implicit reference to the end of therapy'. The following histograms illustrate the distribution of data within each of the items of this category:

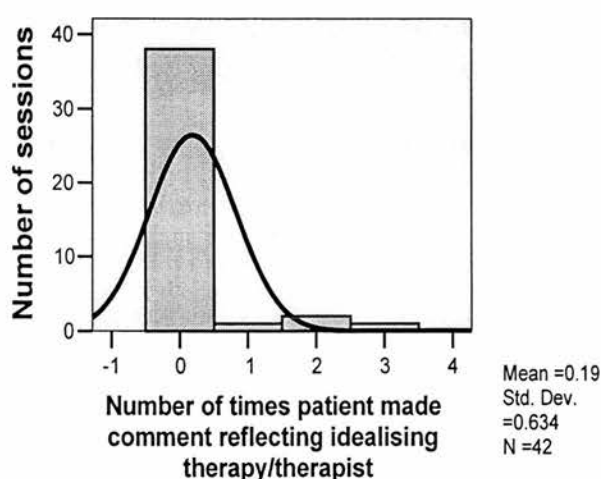


vii. Problematic termination reaction

Table 7 shows items in the category

| Item |
|--|
| Patient raised new problems |
| Patient wanted to extend therapy |
| Patient devalued therapy/therapist |
| Patient idealised therapy/ therapist |
| Patient described an exacerbation of previous symptoms |
| other |

In the category of problematic termination reaction, the item 'patient idealized therapy / therapist' has the lowest corrected item total correlation of -0.001. If this item is removed from the category, the overall Cronbach's alpha of the category rises to .549. Descriptive statistics of items within the category suggest that this item was not frequently coded in the sample. The following histogram illustrates the distribution of data within the item 'patient idealised therapy / therapist':



Summary

Cronbach's alpha indicates that overall there is low internal reliability of items within each category. This finding can be partly explained by data being a frequency count and therefore influenced strongly by low (or non scoring) frequency counts of particular items within a category.

Bollen & Lennox (1991) argue that guidelines about reliability, particularly internal consistency as is being measured here, should always be thought about in the context of the nature of the items that make up a measure. They distinguish between effect indicators and causal indicators, arguing that causal indicators are those that affect the phenomenon being assessed, which means that internal consistency between items of a scale would not necessarily be expected. This applies to the present study in which type of therapy, as a causal indicator, affects the phenomenon being measured (termination activity) and therefore internal consistency between items on the subscale is not necessarily expected.

3.1.2 Inter rater reliability of coding scheme

The inter rater reliability (% agreement) of separate categories in the coding scheme is presented in the table below:

Table 8 showing inter rater reliability of categories

| Category of coding scheme | Inter rater reliability (% agreement) |
|----------------------------------|--|
| Discussion of ending | 85% |
| Evaluation | 83% |
| Closure | 84% |
| Discussion of future | 75% |
| Expression of affect | 80% |
| Implicit reference to ending | 71% |
| Problematic termination reaction | 87% |

Overall percent agreement for the coding scheme was 82%.

3.1.3 Reliability of identification of termination relevant data

Reliability of identification of comments related to termination was computed on a sample of 81 units of data, coded by the researcher from two hour long therapy sessions. An independent coder listened to the same two therapy sessions and there was 84% agreement between the researcher and coder, in terms of comments selected from the sessions as being relevant to the coding scheme.

3.2 Quantitative data analysis

All data was entered into a database in raw form. Variables representing the various categories of the coding scheme were computed for content analysis.

Prior to data analysis all variables were examined for departures from normality, in line with the recommendations for the use of parametric statistics (Greene & D'Oliveira, 1982). Data was presumed to be within acceptable limits for the use of parametric statistics if measures of skewness fell within the range of -2.00 and + 2.00. Tests of normality showed that there was a positive skew to the data across a number of variables. However it was also understood that it has been repeatedly shown that t-tests are generally robust procedures in the presence of departures from parametric assumptions (Pedhazur, 1982).

Bryman & Cramer (2001) note that one exception to the finding that parametric statistics are robust, is where both distributions of scores being compared are non-normal, as is the case in the current study. They advise comparing the results of a non-parametric test with those of a parametric test. Where relevant, in the present study the non parametric equivalent test was also computed and reported following parametric test results.

Levene's test of homogeneity of variance was not significant in the majority of analyses carried out and the parametric assumption of equal variances was assumed (when not assumed it is reported).

3.2.1 Descriptive variables of whole sample

1. Age

The mean age of the sample was 36.9 (s.d.= 12.98), with a minimum age of 19 and a maximum age of 61 . Table 9 summarises the age distribution of the sample. (Due to incomplete data collection, age data were unavailable for 11 participants. The statistics presented therefore are based on 31 participants, 73.81% of total sample).

Table 9 Distribution of age in sample

| | Statistic | Value |
|--------------|------------------------|-------|
| Age in years | Mean | 36.9 |
| | Standard error of mean | 2.3 |
| | Standard deviation | 12.9 |
| | Range | 42 |
| | Minimum | 19 |
| | Maximum | 61 |

Chart 1 shows the distribution of age across the sample

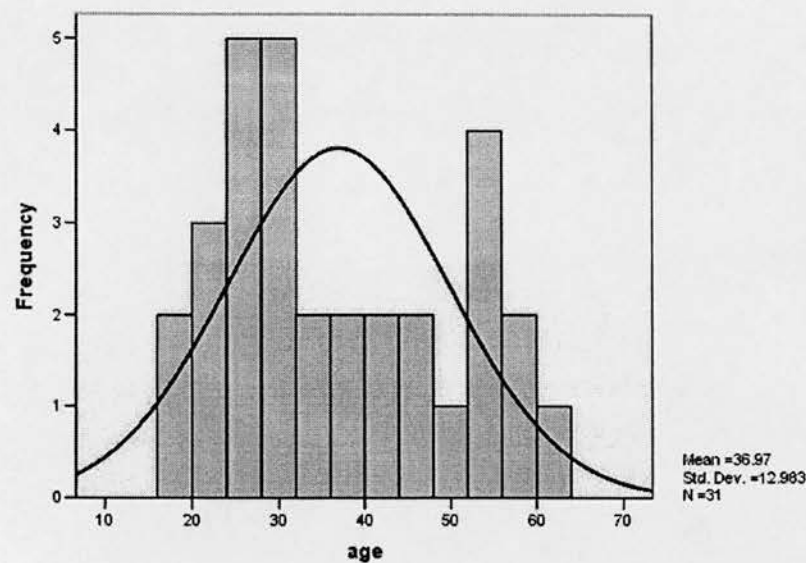


Table 10 Distribution of ages of males and females in sample

| Sex | N | Mean age | Standard deviation | Standard error of mean |
|--------|----|-------------|-----------------------|---------------------------|
| Male | 13 | 33.8 | 10.7 | 3.1 |
| Female | 29 | 39.0 | 14.1 | 3.2 |

The mean age of patients in the CBT group was 39.3 years (s.d. 15.3) in comparison with a mean age of 36 years (s.d. 12.2) in the IPT group. This illustrates the relative equivalence in age, despite the missing data acknowledged previously.

Table 11 Distribution of ages of patients in CBT and IPT samples

| Therapy | N | Mean Age | Standard deviation | Standard error of mean |
|---------|----|-------------|-----------------------|---------------------------|
| CBT | 16 | 39.3 | 15.3 | 5.1 |
| IPT | 26 | 36.0 | 12.2 | 2.6 |

2. Sex

Table 12 summarises the sex distribution of the participants indicating a higher proportion of females in the sample. Of the 42 taped sessions analysed, 13 were of male participants (31.0%), and 29 were of female participants (69%).

Table 12 Sex distribution of total sample

| | Frequency | Percent of total sample |
|---------------|-----------|-------------------------|
| Male | 13 | 31% |
| Female | 29 | 69% |
| Totals | 42 | 100% |

3. Therapy type

Table 13 summarises the proportion of the sample according to type of therapy. Of the total sample of sessions analysed, 16 (38.1%) were CBT sessions and 26 (61.9%) were IPT sessions.

Table 13 Therapy distribution of total sample

| | Frequency | Percent of total sample |
|---------------|-----------|-------------------------|
| CBT | 16 | 38% |
| IPT | 26 | 62% |
| Totals | 42 | 100% |

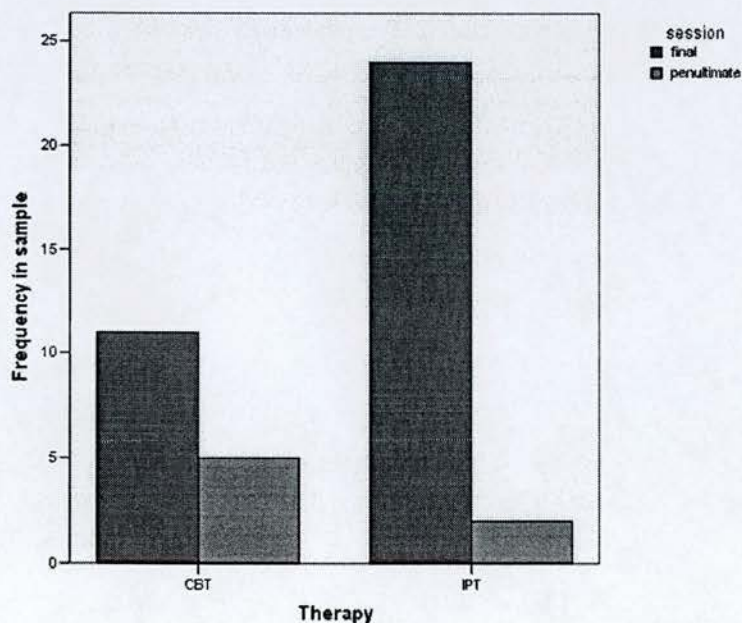
4. Session number

Table 14 shows the percentage of final and penultimate therapy sessions analysed. Of the total sample 35 (83.3%) were final therapy sessions and 7 (16.7%) were penultimate therapy sessions.

Table 14 Session number distribution of total sample

| | Frequency | Percent of total sample |
|---------------------|-----------|-------------------------|
| Final session | 35 | 83% |
| Penultimate session | 7 | 17% |
| Totals | 42 | 100% |

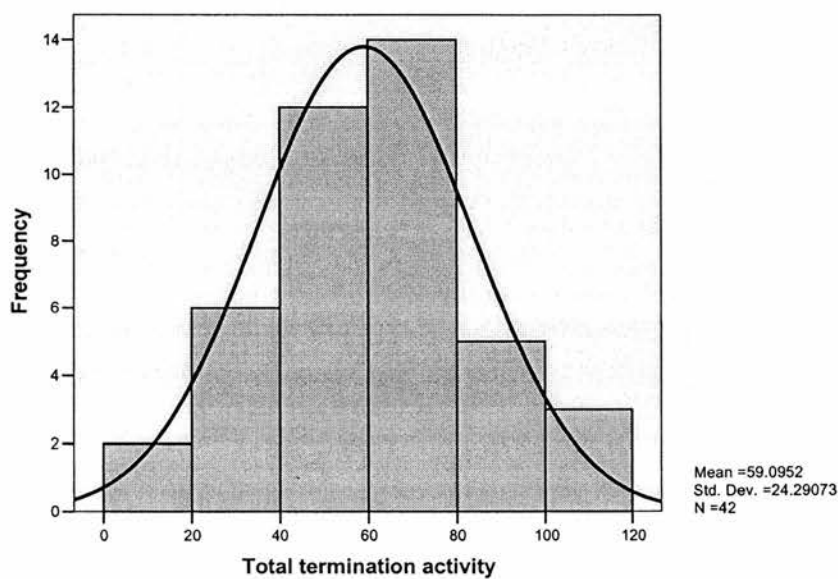
Chart 2 showing frequency of session number in sample according to type of therapy



5. Mean total termination activity

The sample has a mean total termination activity of 59.1 (s.d.= 24.3) comments per session. Chart 3 shows the distribution of termination activity across the sample.

Chart 3 Distribution of termination activity across sample



Summary variables for each termination category were computed. Chart 4 shows the mean amount of termination activity per category, expressed as a percentage of mean total termination activity.

Chart 4 shows mean amount of each category of termination expressed as a percentage of total termination activity.

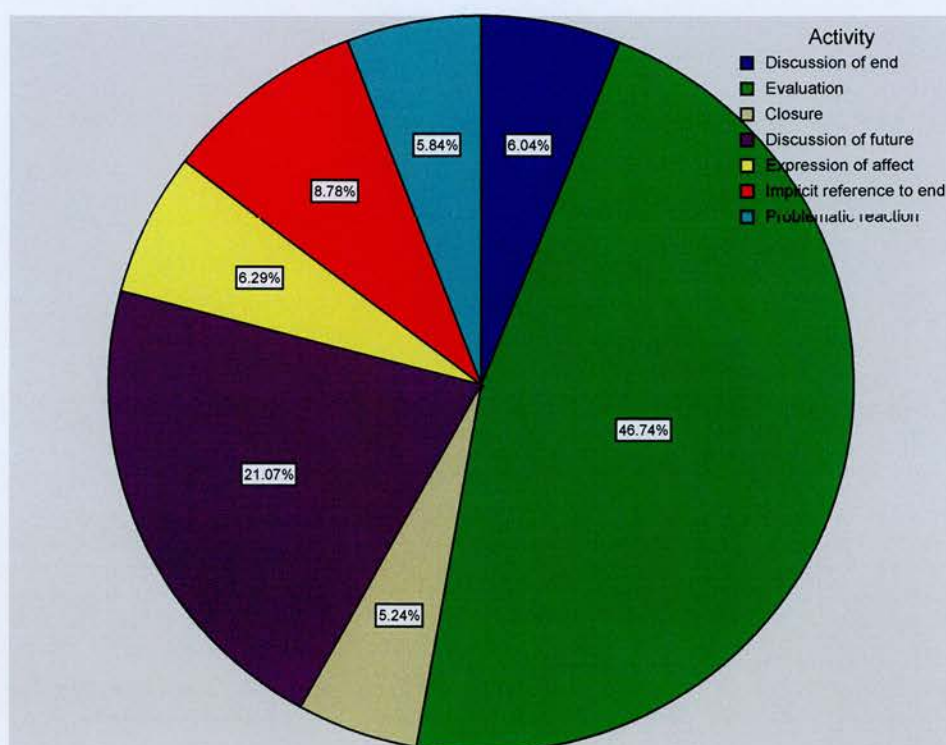


Chart 4 highlights the relatively high percentage of evaluation (47% of total termination activity) as the predominant termination behaviour. With the exception of discussion of the future (21% of total termination activity), all other termination behaviours had a relatively smaller presence in the sample (< 10% respectively of total termination activity).

Mean total termination activity by session

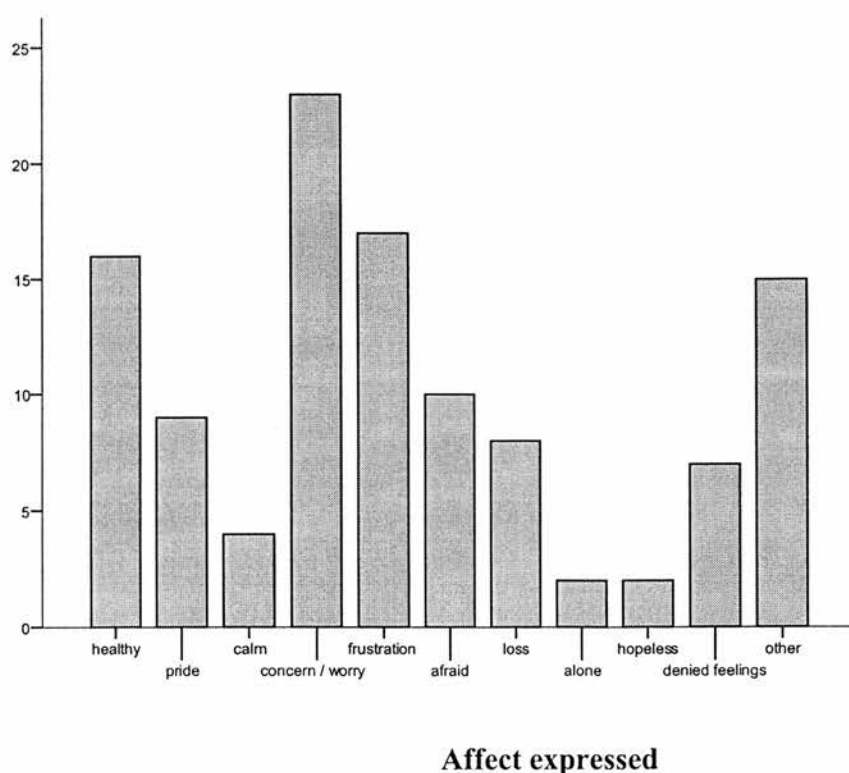
The mean total termination activity in final therapy sessions was 61.97 comments (s.d = 23.18) compared with 44.72 (s.d = 26.42) in penultimate therapy sessions. This comparison was based on the sample in which 83% of sessions analysed were final

sessions, the remaining 17% were penultimate sessions, as mentioned previously in section 4.

6. Expression of affect about ending therapy

Literature on termination of therapy, described in the introduction section to this study, highlight the patient's expression of emotion about ending therapy as an important aspect of termination. In the present study the average amount of expression of affect (per session) was 3.7 comments (s.d.=3.2), which is 6.3% of mean total termination activity (per session). The following chart displays the sum total of comments categorised as an expression of a particular feeling about ending therapy.

Chart 5 Total number of comments per item of expression of affect about ending therapy (excluding 'therapist facilitates expression of affect')



The chart highlights feeling ‘healthy’, ‘concern/worry’, ‘frustration’, or other feelings not included, as the predominant feelings expressed by patients at the end of therapy.

3.2.2 Comparative analysis of CBT and IPT

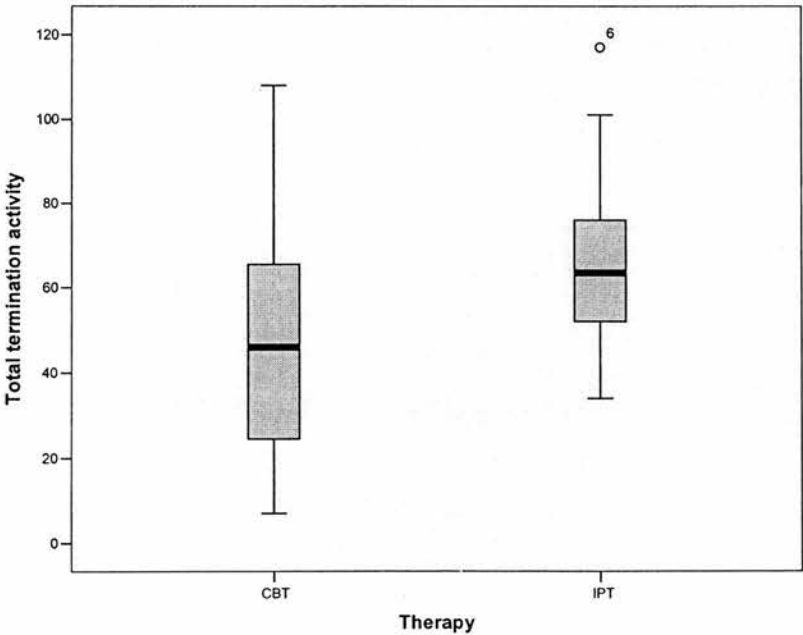
1. Total termination activity

The first hypothesis predicted that IPT would have a significantly greater amount of total termination activity in the final sessions of therapy, than CBT.

A comparison of CBT and IPT on total termination activity shows that IPT has a mean total termination activity of 65.2 across the sample (s.d.= 20.2), whereas CBT has a mean total termination activity of 45.2 across the sample (s.d = 27.8).

The following boxplot illustrates the difference in total termination activity between CBT and IPT.

Boxplot 1 Difference in total termination activity between CBT and IPT



An independent samples t-test for equality of means showed that in IPT there was a significantly greater amount of termination activity, compared to CBT ($t=2.150$, $df = 40$, $p=0.019$, one-tailed test). Results from the Mann–Whitney U-test, as a non parametric equivalent, also support this finding ($U=133.50$, $N=42$, $p= 0.027$, one-tailed test).

2. Categories of termination activity

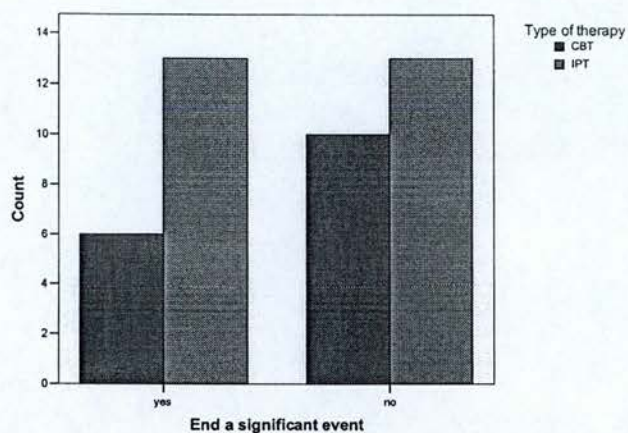
The second hypothesis predicted that there would be specific differences in terms of termination activity per category of termination, during final sessions of CBT and IPT. More specifically in IPT there would be greater activity regarding: discussion of the end of therapy; closure of the therapeutic relationship; evaluation of therapy; discussion of the future; and patient expression of affect regarding the end of therapy, in comparison with CBT.

Results of independent samples t-tests for equality of means between CBT and IPT, in the seven categories of termination are presented in the following sections i to vii:

i. Discussion of the end of therapy

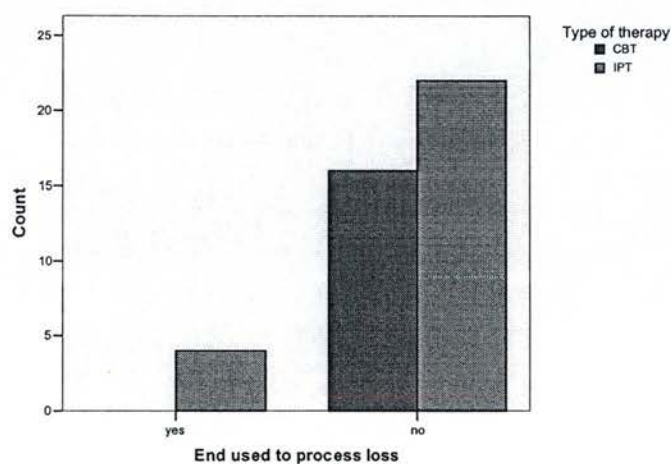
The following charts illustrate a comparison of CBT and IPT in terms of whether the end of therapy was perceived as a significant event (chart 6); and whether the end of therapy was used to process the patient's experience of loss (chart 7):

Chart 6 A comparison between CBT and IPT of the 'end was a significant event'.



A chi-squared analysis did not find a significant difference between CBT and IPT in terms of whether the end of therapy was perceived as a significant event.

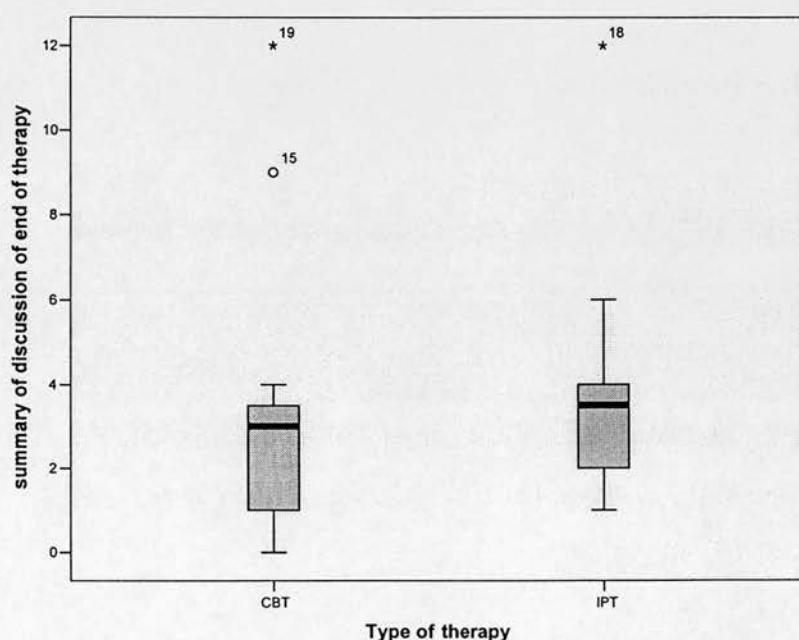
Chart 7 A comparison between CBT and IPT of the 'end of therapy was used to process the patient's experience of loss':



(A chi squared analysis could not be computed as 2 cells (50%) had an expected count fewer than 5).

The remaining 4 items in the category were computed into a summary variable of 'discussion of the end of therapy', as they were a frequency count of the number of comments coded in each session (as opposed to a categorical 'yes/no' response described in the previous items). CBT and IPT differ in terms of the average amount of discussion about the end of therapy (CBT mean =3.56, s.d.=3.95; IPT mean =3.58, s.d.=2.14). The following boxplot illustrates this comparison.

Boxplot 2 Summary scores for discussion of the end of therapy in CBT and IPT samples



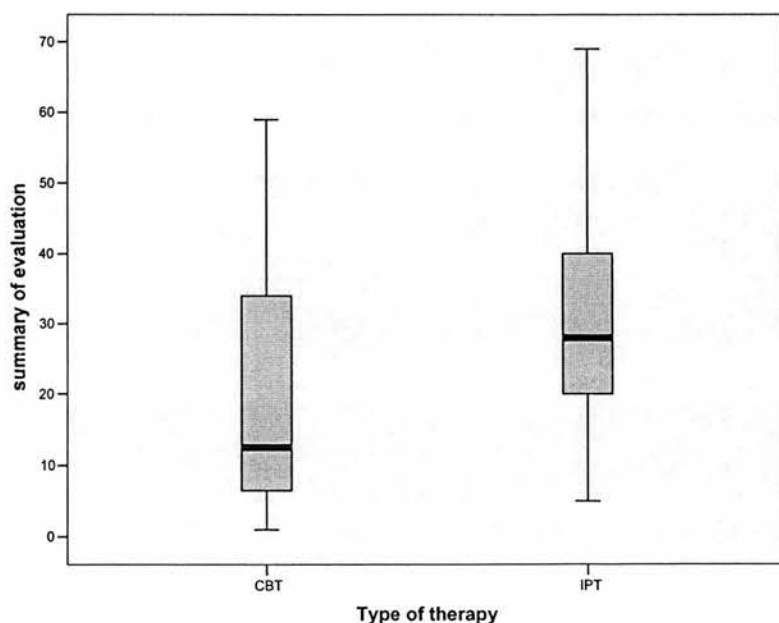
An independent samples t-test for equality of means between CBT and IPT on discussion of the end of therapy did not find a significant difference between the groups ($t= 0.13$, $df=20.50$, $p=0.989$, equal variances were not assumed). Results from the Mann-Whitney U-test, as a non-parametric equivalent support this finding ($U=153.00$, $N=42$, $p=0.14$).

Therapist mentioning the end of therapy, was the most frequently observed item of the category. A comparison between CBT and IPT shows that the mean number of times the therapist mentioned the end in each CBT session was 1.69 (s.d=1.25), in comparison with 2.69 (s.d = 1.44) in IPT sessions. An independent samples t-test to compare the means was carried out and the difference was found to be significant ($t=2.310$, $df=40$, $p=0.026$). Results from the Mann-Whitney U-test also support this finding ($U=128.00$, $N=42$, $p=0.016$).

ii. Evaluation of therapy

CBT and IPT differ in terms of the mean amount of evaluation of therapy during sessions (CBT mean =20.63, s.d.=17.84; IPT mean =31.92 , s.d.=16.96). The following boxplot illustrates this comparison.

Box plot 3 Summary scores for evaluation of therapy in CBT and IPT samples

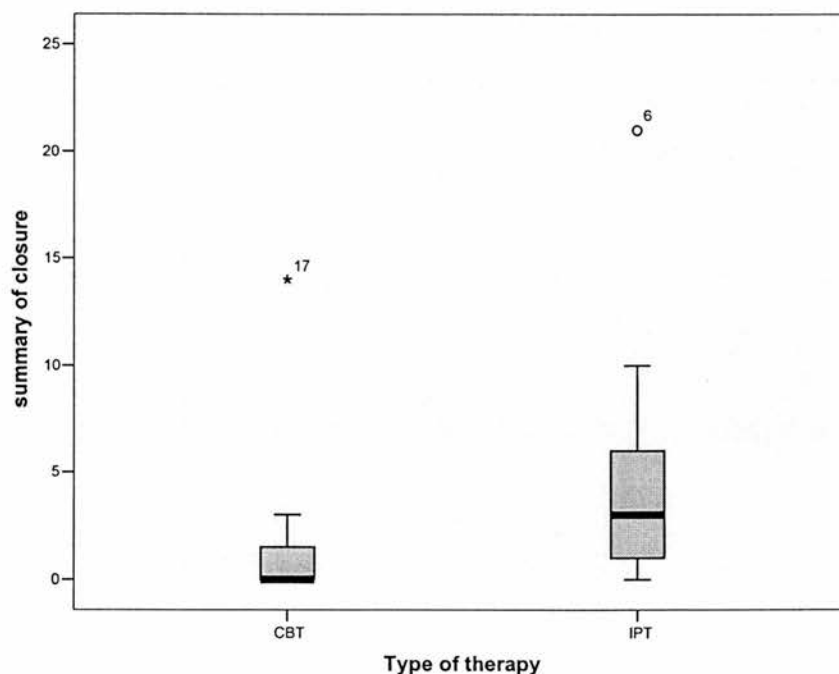


An independent samples t-test for equality of means, showed that in IPT there was a significantly greater amount of evaluation of therapy, in comparison to CBT ($t = 2.056$, $df=40$, $p=0.023$, one-tailed test). Results from the Mann–Whitney U-test, as a non parametric equivalent, also support this finding ($U=129.00$, $N=42$, $p=0.02$, one-tailed test).

iii. Closure of the therapeutic relationship

CBT and IPT differ in terms of the average amount of closure of the therapeutic relationship (CBT mean= 1.44, s.d. = 3.48; IPT mean =4.12, s.d. =4.77). The following boxplot illustrates this comparison.

Boxplot 4 Summary scores for closure of the therapeutic relationship in CBT and IPT samples



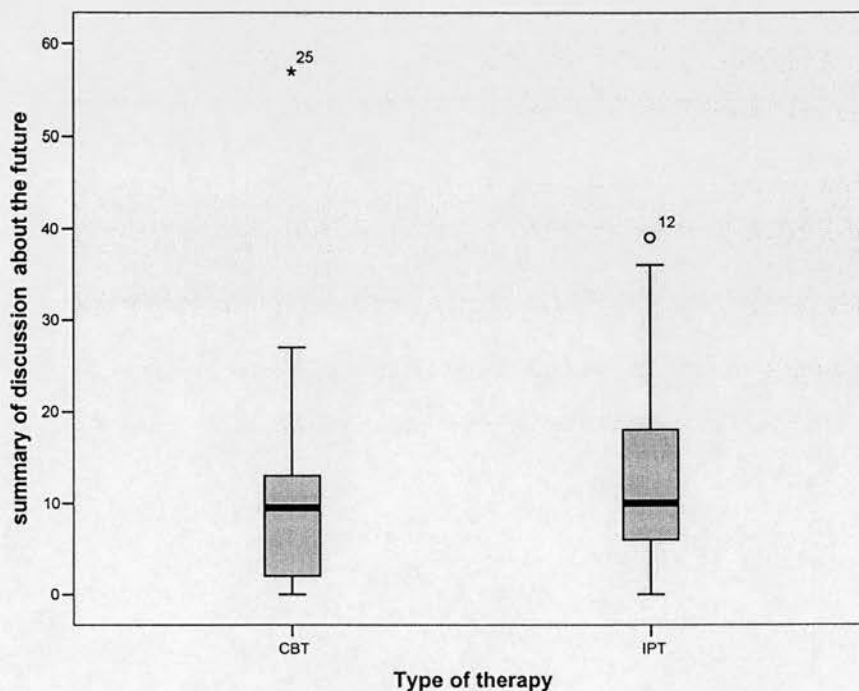
An independent samples t-test for equality of means showed that in IPT there was a significantly greater amount of closure of the therapeutic relationship in comparison to

CBT ($t = 1.946$, $df = 40$, $p = 0.0295$, one-tailed test). Results from the Mann–Whitney U-test, as a non parametric equivalent, also support this finding ($U = 104.50$, $N = 42$, $p = 0.003$, one-tailed test).

iv. Discussion of the patient's future plans

CBT and IPT differ in terms of the average amount of discussion of the patient's future plans during sessions (CBT mean = 11.69, s.d.=14.12; IPT mean = 12.92, s.d.=10.55). The following boxplot illustrates this comparison.

Boxplot 5 Summary scores for discussion of the patient's future plans in CBT and IPT samples



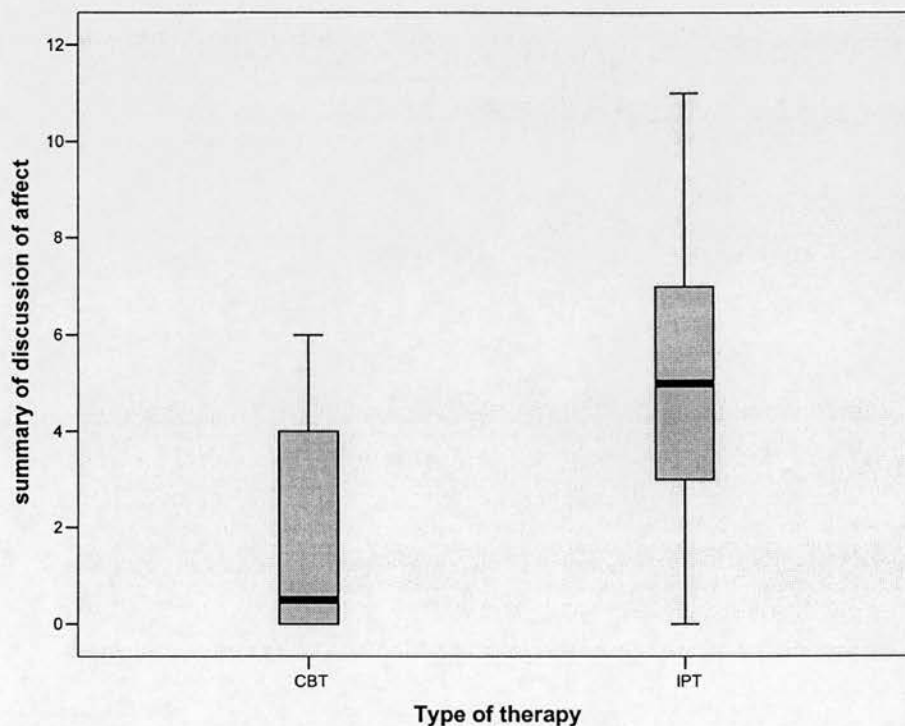
An independent samples t-test for equality of means between CBT and IPT on discussion about the future did not find a significant difference between the groups ($t = 0.324$, $df = 40$,

$p=0.38$, one-tailed test). Results from the Mann–Whitney U-test, as a non-parametric equivalent, also support this finding ($U=175.00$, $N=42$, $p=0.19$, one-tailed test).

v. Expression of affect about ending therapy

CBT and IPT differ in terms of the average amount of expression of affect about ending therapy during sessions (CBT mean = 1.69, s.d.=2.15 ; IPT mean = 4.96, s.d. = 3.14) and also in terms of the distribution of summary scores across the respective samples. The following boxplot illustrates this comparison.

Boxplot 6 Summary scores for expression of affect in CBT and IPT samples

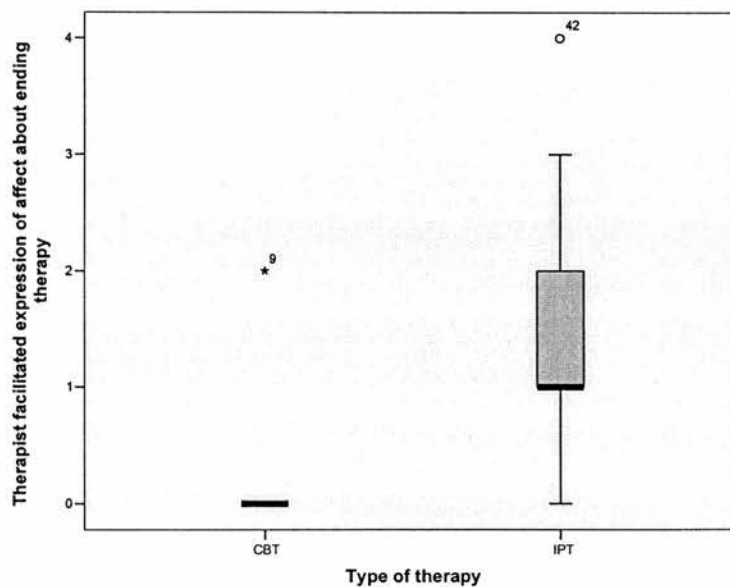


An independent samples t-test for equality of means showed that in IPT there was a significantly greater amount of expression of affect about the ending of therapy, compared to CBT ($t=3.664$, $df=40$, $p=0.0005$, one-tailed test). Results from the Mann–

Whitney U-test, as a non parametric equivalent, also support this finding ($U=81.50$, $N=42$, $p=0.0005$, one-tailed test).

A difference was found between CBT and IPT in terms of the item 'therapist facilitates expression of affect'. CBT mean = 0.38, s.d.= 0.81; IPT mean = 1.42, s.d.=1.14. The following boxplot illustrates this comparison:

Boxplot 7 A comparison between CBT and IPT for therapist facilitation of expression of affect about ending therapy

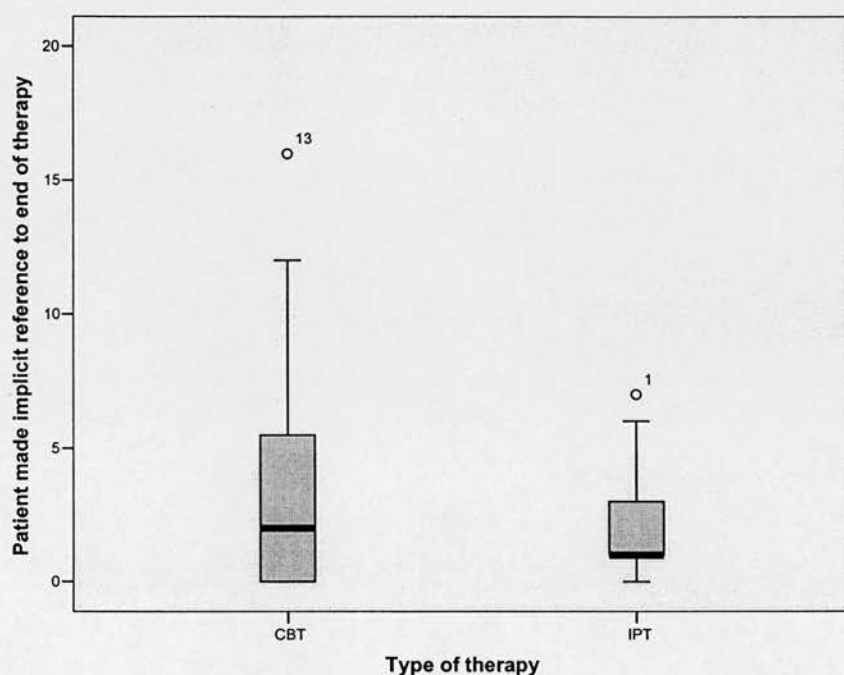


An independent samples t-test between CBT and IPT on this item showed that there was a significantly greater amount of therapist facilitation of expression of affect in IPT, compared to CBT ($t=3.125$ $df=40$, $p=0.03$). Results from the Mann–Whitney U-test, as a non parametric equivalent, also support this finding ($U=93$, $N=42$, $p= 0.002$).

vi. Patient made implicit reference to end of therapy

CBT and IPT differ in terms of the average number of implicit references made to the end of therapy (CBT mean =3.88, s.d.=4.79; IPT mean =2.04, s.d.=2.13). The following boxplot illustrates this comparison.

Boxplot 8 Summary scores for the category ‘patient made an implicit reference to the end of therapy’ in CBT and IPT samples



An independent samples t-test for equality of means between CBT and IPT for the patient making an implicit reference to the end of therapy, did not find a significant difference between the types of therapy ($t=1.449$, $df=18.69$, $p=0.16$, equal variances were not assumed). Results from the Mann–Whitney U-test, as a non parametric equivalent, also support this finding ($U=179.5$, $N=42$, $p=0.45$).

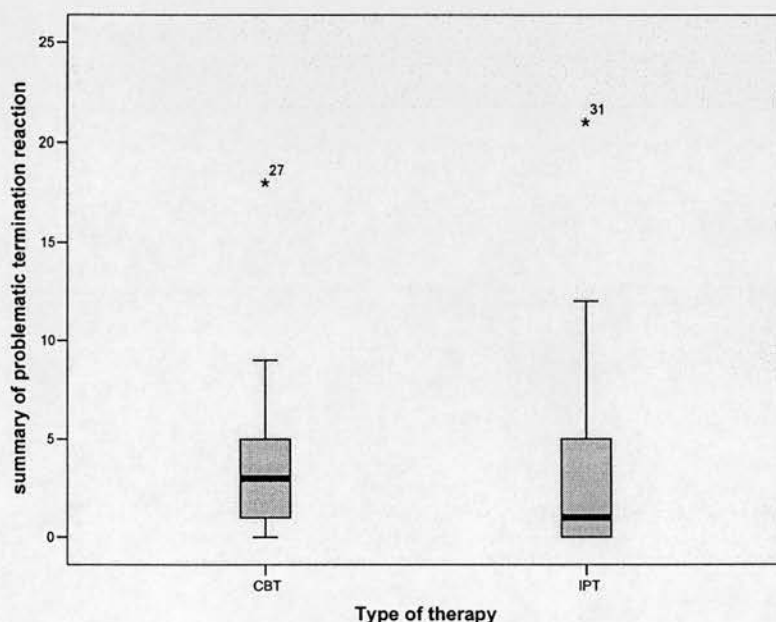
In terms of the therapist’s acknowledgement of the implicit reference made by the patient, there was a greater mean amount of acknowledgement in IPT (mean = 1.08, s.d.=

2.06) in comparison with CBT (mean=0.06, s.d =0.25). An independent samples t-test for equality of means between CBT and IPT found this difference to be significant ($t=2.484$, $df=26.19$, $p=0.02$, equal variances were not assumed). Results from the Mann–Whitney U-test also support this finding ($U=137.5$, $N=42$, $p=0.018$).

vii. Problematic termination reaction

CBT and IPT differ in terms of the mean amount of problematic termination reactions during sessions (CBT mean =4.00, s.d.=4.60; IPT mean =3.12, s.d.=4.84). The following boxplot illustrates this comparison.

Boxplot 9 Summary scores for problematic termination reactions in CBT and IPT samples

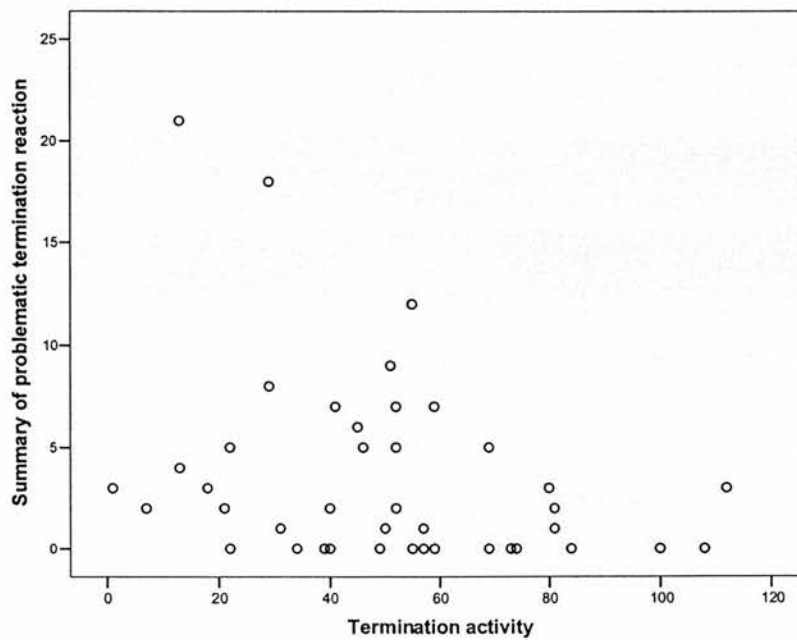


An independent samples t-test for equality of means between CBT and IPT on problematic termination reaction did not find a significant difference between the types of therapy ($t=0.585$, $df=40$, $p=0.56$). Results from the Mann–Whitney U-test, as a non parametric equivalent, also support this finding ($U=164.5$, $N=42$, $p=0.25$).

A two-tailed bivariate Pearson correlation was carried out to assess the relationship between problematic termination reaction and total amount of termination activity (termination activity excluded categories for 'problematic termination reaction' and 'patient made implicit reference to the end of therapy'). A significant moderate negative correlation was found between the two variables ($r = -.31$, $N = 42$, $p = 0.044$).

The following scattergram illustrates the relationship between termination activity and problematic termination reaction:

Scatterplot of problematic termination reaction and termination activity



Summary of results

The following table summarises main findings of descriptive and comparative analyses described in the previous sections i to vii.

Table 15 Descriptive statistics and t-test significance

| Summary category | Therapy | Mean number of comments | Standard error of mean | Standard deviation | t value | Significance level (<0.05) |
|--------------------------------------|---------|-------------------------|------------------------|--------------------|---------------|----------------------------|
| Total termination | CBT | 45.2 | 6.95 | 27.8 | -2.150 | 0.019 |
| | IPT | 65.2 | 3.94 | 20.2 | | |
| Discussion of end | CBT | 3.56 | 0.98 | 3.95 | | |
| | IPT | 3.58 | 0.42 | 2.14 | | |
| Evaluation | CBT | 20.62 | 4.46 | 17.84 | -2.056 | 0.023 |
| | IPT | 31.92 | 3.33 | 16.96 | | |
| Closure | CBT | 1.44 | 0.87 | 3.48 | 1.946 | 0.0295 |
| | IPT | 4.12 | 0.94 | 4.77 | | |
| Discussion of future | CBT | 11.69 | 3.53 | 14.12 | | |
| | IPT | 12.92 | 2.07 | 10.55 | | |
| Expression of affect | CBT | 1.69 | 0.54 | 2.15 | 3.664 | 0.0005 |
| | IPT | 4.96 | 0.62 | 3.14 | | |
| Implicit reference to end of therapy | CBT | 6.25 | 1.68 | 6.74 | | |
| | IPT | 4.54 | 0.91 | 4.66 | | |
| Problematic reaction | CBT | 4.00 | 1.15 | 4.60 | | |
| | IPT | 3.12 | 0.95 | 4.84 | | |

3. Relationship between therapeutic change and termination activity

The third hypothesis predicted that there would be a positive correlation between amount of termination activity and change in:

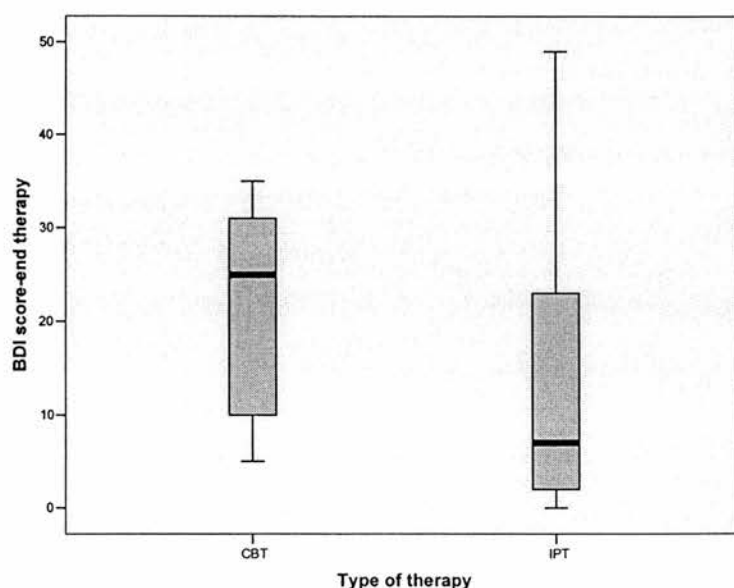
- 1) level of depression (measured by change in BDI score over therapy) and;
- 2) level of anxiety (measured by change in HADS score for anxiety over therapy).

i. Change in level of depression

Change in depression score was computed for 30 patients (CBT N=9; IPT N=21) of the sample of 42. The outcome data for 12 patients was missing.

An initial comparison shows that at the end of therapy there was a higher mean BDI score for patients who had CBT (mean = 21.00, s.d =11.39) in comparison to patients who had IPT (mean = 12.90 , s.d = 13.84). This difference was not evident when patients were first recruited to the study and a baseline BDI was taken (CBT mean = 31.44, s.d.=10.37; IPT mean = 30.67, s.d.=10.82).

Boxplot 10 A comparison between CBT and IPT of BDI scores at the end of therapy



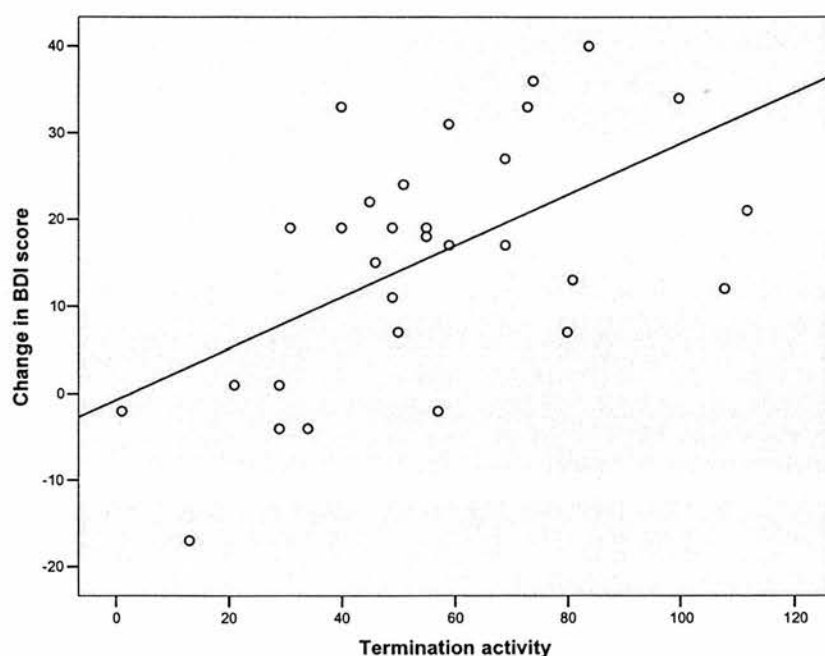
An independent samples t-test for equality of means showed that there was no significant difference between CBT and IPT in mean BDI scores at the end of therapy.

In order to assess the relationship between successfulness of therapy (in terms of symptom reduction during therapy) and total termination activity, the change in score for depression was computed (by subtracting BDI scores at the end of therapy from those at the start).

The mean change in depression score for patients who had CBT was 10.44 (s.d =13.54) compared to the mean change in score for patients who had IPT (17.76, s.d =13.75). An independent samples t-test was computed to compare the mean amount of change in depression, between CBT and IPT and no significant difference was found.

The following scatterplot illustrates the relationship between change in symptoms of depression and termination activity.

Scatterplot of change in BDI score and termination activity



A two-tailed bivariate Pearson correlation was carried out to assess this relationship (termination activity did not include categories 'problematic termination reaction' and 'patient made implicit reference to the end of therapy'). A significant, moderate positive correlation was found between the two scores ($r = .560$, $N=30$, $p = 0.005$, one-tailed).

ii. Change in level of anxiety

The amount of change in level of anxiety, was computed for 25 patients (CBT N=8; IPT N=17) of the sample of 42. The outcome data for 17 patients was missing.

At the end of therapy patients who had CBT had a higher mean score for anxiety (11.25, s.d.= 5.68) in comparison to those patients who had IPT (mean =5.78, s.d.=3.96). This difference was also apparent when baseline scores were compared (CBT mean = 15.00, s.d.=2.45; IPT mean = 11.45, s.d.=3.44).

An independent samples t-test for equality of means found a significant difference between CBT and IPT on scores for anxiety at the end of therapy ($t=2.843$, $df=24$, $p=0.009$). This difference was also found to be significant for baseline scores for anxiety ($t=2.782$, $df=27$, $p=0.01$).

Change in anxiety level was computed by subtracting anxiety level, as measured by HADS, at the end of therapy from baseline scores for anxiety. The mean change in anxiety score for patients who had CBT was 3.50 (s.d =4.28) compared to the mean change in score for patients who had IPT (5.35, s.d =3.79). An independent samples t-test was computed to compare the mean amount of change in level of anxiety, between CBT and IPT and no significant difference was found.

A two-tailed bivariate Pearson correlation was also carried out to assess the relationship between change in level of anxiety and termination activity (termination activity did not include categories 'problematic termination reaction' and 'patient made implicit reference to the end of therapy'). The correlation found was small and non significant ($r=.197$, $N=25$, $p=.173$, one-tailed).

3.3 Qualitative commentary on termination content of sessions

The present study has described from a quantitative perspective, how termination is approached in CBT and IPT. In the following section termination activity is explored and described in more detail, using transcribed excerpts from the sessions analysed. The aim of this is to illustrate more fully the nature of termination behaviours observed and where relevant make a comparison between CBT and IPT in qualitative aspects of termination activity.

A discourse analytic approach is concerned with the detailed analysis of talk and texts, paying close attention to features which would traditionally be classed as linguistic content, meanings and topics, as well as attending to linguistic features such as grammar (Potter & Wetherell, 1994). The approach is concerned with action in speech, in essence this refers to what people are trying to do through their talk. Whilst this approach is by no means adopted for the qualitative analysis of the present study, due to time restrictions and the nature of the study as a content analysis, discourse analytic concepts have been used as a broad basis for the current section.

3.3.1. Researcher's stance

Qualitative research emphasises the importance of the researcher's perspective on the data being investigated. Although reflections have not been formally recorded during the research process, as they might have been in a purely qualitative study, the current section describes the researcher's perspective and reflects on how this may have influenced the coding process.

As a trainee clinical psychologist I had experience of working therapeutically with patients, particularly using CBT and psychodynamic psychotherapy. In many ways the

two experiences were illuminating in their differences with regard to the ending of therapy. My experience of CBT left me with an impression that the end of therapy was not explicitly recognised in terms of the ending of a relationship. Rather the focus of latter sessions seemed to be restricted to a review of the skills and techniques acquired for managing psychological distress, and a discussion of future relapse prevention. It was always with some sadness and anxiety that there was a relatively reduced focus on the emotional content of final sessions, in particular any acknowledgement of difficult feelings on behalf of the patient or therapist. In the early stages of training, it was not that these feelings were deliberately ignored, but that there was uncertainty on my behalf around how to best facilitate discussion of them with the patient.

My experience working in a psychodynamically orientated psychotherapy department for my final year placement, was that from the very beginning of working with a patient, the ending of therapy was discussed. The importance of the termination phase in therapy was emphasised to the opposite extreme. I almost felt as if too much was made of the ending of therapy, or missed sessions as a prelude to an eventual termination in therapy. However I soon came to understand the importance of openly discussing how the patient feels about therapy ending, as was sometimes evoked when a session was missed, cancelled or re-arranged due to me being on holiday, for example.

The outcome of these experiences, on my own perspective towards termination in therapy, has potentially unwittingly biased my interpretation of material, towards IPT. My understanding of this is that I might tend to observe comments in IPT as related to termination, in comparison to similar comments made in CBT sessions. IPT as a therapy recognises the importance of the ending of therapy and allocates this an explicit phase, to

explore the end of the therapeutic relationship, as well as a time to consolidate gains and look to the future.

3.3.2. Selection of excerpts for discussion

Examples of each termination category were selected to provide an illustration of the content analysed in sessions, and are presented in the following sections i to vii. This approach provides a means of complimenting quantitative findings, considering data from a closer perspective.

Items within a category not illustrated with an example, are either because they were not observed or the item was felt to be self explanatory (e.g. item ‘patient wanted to extend therapy’ in the closure category of termination).

Excerpts presented here were selected in which the researcher was able to identify a qualitative difference between CBT and IPT in terms of the content of comments made.

i. Discussion of the end of therapy

The following examples broadly describe the item ‘the end was used to process the patient’s experience of loss’ (although they also include other items such as ‘patient mentioned the end of therapy’, for example). The end being used to process the client’s experience of loss was coded subjectively based on the rater’s perception of the session as a whole. It was experienced as difficult to categorise due to difficulty in identifying ‘using the end to process’ in action. This was defined as discussion during session of loss experiences, with an explicit recognition of the parallel between loss experiences and the end of therapy. Definition of loss referred to any loss experience, not specifically bereavement.

An example from IPT:

The following excerpt is from the final IPT session of a patient whose sister had recently died:

(Pt = Patient; Th = Therapist)

(Pt 41)

Pt: I've been a bit concerned, thinking, is this the depression coming back again?, but I suspect a lot was just a reaction to my sister's death you know, I found it hard to lift myself, I've been suppressed by grief.

Th: It's important to remember that you're living right now with a great loss. We need to distinguish that from depression, it's important to consider as we face our last session together, the timing can seem quite poignant...there's the importance of giving yourself time to heal through the bereavement...when we look through the symptoms, they're very low

The therapist gives the patient permission to feel sadness as a result of the recent bereavement and the emphasis is placed on the sadness being distinct from feelings of depression, by naming the 'bereavement'.

(Pt 41)

Pt: ...at the moment there's a feeling, 'will I remember everything I've learned here?'. That comes with the timing as well. I kept thinking this week that I might forget everything. It's a horrible feeling to think that I might forget what I've learned. I think that's scary

Th: I wonder whether right now something of what needs to be discussed is the fear, in the midst of all this (grief) thinking 'I'm also finishing therapy, I'm afraid I'll forget bits'...

The loss of a loved one coincides with the patient's loss of the therapeutic relationship. This evokes feelings of anxiety that the progress made is unstable and temporary, and might be 'forgotten'.

Th: I think we've created something for you to take confidence in, even with the setback of the moment, the pain of the loss, we've created something so real, we can take confidence in it not slipping away, even in the loss you continue to live out the changes and what you're able to say is 'I know it's there for me, and I'll come back to that, I just have other things that demand my attention just now'.

Towards the end of the same session the therapist reassures and comforts the patient, emphasising for the patient the therapeutic gains that have been made and that they will have permanence. By using 'we' a sense of togetherness is created and the therapist speaks as if the patient, as a means of powerfully reassuring the patient. Overall the excerpts from this case illustrate the concerns of a patient who is experiencing two loss experiences and feels anxious that progress in therapy has been lost. In response to this the therapist adopts techniques of reassurance and persuasive argument to comfort the patient that therapy has been worthwhile.

An example from CBT in which a female patient remembers her Mother's funeral:

(Pt 15)

Pt: (my cousin) was sitting behind me, just sobbing you know, and I just felt like saying 'be quiet', cos she was just making such a racket!

Th: how did that make you feel?

Pt: well, she's my mother, if anyone is going to be crying like that it should be me, but I wasn't

During this excerpt the patient sounds very tearful. She describes a number of bereavements that she feels she has not fully come to terms with. In response the therapist facilitates her expression of loss but does not 'use the end of therapy' to facilitate this process, as the item in the coding scheme suggests. There were no examples in CBT in which the 'end of therapy was used to process the patient's experience of loss'.

ii. Evaluation of therapy

The items of evaluation as defined in the coding scheme refer to the review of any aspect of the therapeutic process and its impact on any aspect of the patient's experience. Items included 'summarising the work' (patient or therapist); 'assessing the extent to which goals were achieved'; 'patient stating likes or dislikes about therapy'; 'patient asking questions about how therapy works'; and 'other'.

An example from IPT:

(Pt 39)

Pt: I'm fine really, working, keeping busy, not having much stress about anything! I've seen friends, people have been up visiting so I've been feeling quite happy...

Th: so there's been a nice balance

Pt:if problems have arisen I just listen to myself and do what feels right. Something came up with David (boyfriend) and I thought he was seeing someone, I was getting jealous, so I talked him into saying how he felt and that seemed to really work....

Th: that certainly sounds more confident

It was my impression that in IPT the patient often placed an emphasis on the positive development of relationships as a consequence of therapy. In response the therapist compliments and summarises the comments made by the patient in the evaluative process.

An example from CBT:

(Pt 24)

Th: Do you find it useful yourself, keeping a diary?

Pt: Yeh, it's helped me plan things out, keeps me occupied

Th: It might be a good thing to do, thinking over the sessions, I've noticed that how you fill your time, what you do, is quite important to how you feel

In CBT evaluation of therapy seems more focused on behaviours and thought challenging techniques that have been found to be effective, as opposed to interpersonal factors in IPT. The CBT therapist, in the following example comments on something she has noticed about the patient and there is a sense of the patient taking action to manage her feelings as a consequence of therapy.

(Pt 15)

Pt: I think over the last month and half, things have improved, I've been more in control, able to do things I wasn't able to do before...every thought that's come into my head, I've done the opposite...that's too glib maybe....but I have, and that has made a difference

Patient 15 refers to using her thoughts to manage how she feels and the improvement she has noticed as a result. She alludes to a greater sense of self efficacy.

A number of analogies were made by both patient and therapist in which attending CBT is described as a process in which skills are learned. The therapist emphasises the collaborative and educational aims of CBT.

(Pt 28)

Th: What you've done is develop techniques and skills...at the start of therapy I see myself as a tool box with the patient as mechanic, but they don't know how to use the tools. Now you're the toolbox, you know what to use, what works for what...

The following comment illustrates the challenging nature of therapy, 'competing against' psychological distress with some degree of success. At the same time there is disappointment associated with incomplete success of the techniques learned:

(Pt 14)

Pt: It's like a tennis match, my mind is constantly throwing things at me, I just couldn't cope, but the techniques I've learned helped me to every now and then return a ball, but there's no way I was gonna win a match!

CBT is depicted as a life saving resource, albeit with limited success for this particular patient. On reflection it might be easier for her to express dissatisfaction with therapy in the context of an analogy (see also previous tennis match example):

(Pt 10)

Pt: When I was drowning I was able to get my head floating again, I couldn't come up completely out of the water but at least I could get my head above water!

The learning process analogy is used to highlight the arduous nature of acquiring unfamiliar skills and techniques, particularly without the support of the therapist when therapy has ended:

Pt 10: It's like learning a language, you can buy the books, and say yeh, I'll do an exercise everyday, but I'm just slightly concerned that after a couple of weeks you run out of steam and don't do it, but if you're going to classes everyday, with a teacher, you have to do the exercises....it's a lot easier to learn a language

iii. Closure of the therapeutic relationship

It seemed that often, in both CBT and IPT, the final session ended due to having run out of time, as if therapy was cut short in some way. For example:

(Pt 25) (IPT)

Th: 'OK, it's time to stop now I'm afraid'

When considering whether to code this type of comment, I decided that this was not an example of closure as defined according to the items of the category, rather it was a pragmatic expression on the therapist's behalf, to bring the session to a close.

It was my impression that closure of therapy as defined by the coding scheme, occurred most frequently towards the end of the final therapy session.

The most common item in both therapies, was an expression of gratitude on the patient's behalf.

An example from IPT:

(Pt 5)

Th: Enormous congratulations! We can see this as a point of completion or ending, but it's equally valid I think to see it as a point of graduation, I've done what I came here to do, I've managed.

In IPT closure was also sometimes expressed as a period of graduation from a state of depression (comments of this type were coded 'other'). There is an atmosphere of celebration that was not apparent in any of the CBT sessions. This led me to wonder if the patient experienced this as a pressure to get better for the therapist. Taken out of context it sounds as if the therapist is talking about herself, in her last statement, 'I've done what I came here to do, I've managed', when in fact she is talking as if she were the patient.

In IPT it was also noticed that the therapist would share feelings about therapy with the patient (which was a new item not included in the original TBC-T):

Case 5: (IPT)

Th: It's been a real pleasure as well...I've really enjoyed working with you.

Alongside feelings of gratitude, which was the most commonly observed expression of closure to the therapeutic relationship it was apparent that the ending of therapy at times was also experienced as awkward. A consequence of this may be the patient asks personal questions or makes personal comments about the therapist. This seemed to me to be an attempt at further intimacy, seeking to maintain the relationship established outside of therapy:

Pt 16 (CBT)

Pt: I just want to say I appreciate the time that you've spent with me. I must admit, I was very suspicious at first and also was very distressed to find that you were so young, I think if you'd have been a boy I'd have really walked out!

This interesting comment expresses gratitude, at the same time as making a personal comment about the therapist. By sharing this previous unexpressed reservation about the therapist, at this late stage in therapy, it could be interpreted as an attack on the therapist, for ending therapy and not being open to maintaining the relationship outside of therapy.

iv. Discussion of plans for the future

In both CBT and IPT discussion of future goals, hopes and aspirations was common:

An example from IPT:

(Pt 34)

Th: It's about putting things in place that will engage you now, and in the future....what is achievable

Pt: Yeh, it is, what's achievable...

Th: What dreams can you put in place? Be positive and specific. 'What can I continue? What can I develop, start or try out?'

The therapist facilitates discussion of the future in a way that encourages the patient to be hopeful. There is a sense that if dreams can be realised in some way, the future is positive, or even bright and exciting. The patient, by repeating what the therapist has said at the end of the first excerpt described, illustrates his willingness to consider the future in a positive light.

An example from CBT:

(Pt 24)

Pt: realistically, I'll just have to find whatever work is available

Th: have you been able to look at what kind of work you might fit in?

Pt: maybe supermarket work, stacking shelves

In an excerpt from CBT the therapist helps the patient to think practically about work opportunities. Overall it was my impression that there was not an obvious qualitative

difference between CBT and IPT in terms of discussion of the future. It seemed that discussion of the future was sometimes used, in both types of therapy, to reassure and instill hope and positivity for life after therapy.

Discussion of relapse prevention was also a common activity in both CBT and IPT. It involved consideration of the return of symptoms in the future.

An example from IPT:

Pt (23)

Pt: I do kind of have the feeling that if I carry on like this I'll find myself in difficulty again

The patient expresses a concern that I felt was common in both types of therapy; that problems would return.

An example from CBT:

(Pt 24)

Th: how about in the last few minutes writing down a few things for yourself, that have been most helpful, so that if things get difficult, you can look at the list and see what has helped?

In this example a practical task gives the patient something tangible to take away at the end of therapy. This coincides with CBT as a set of techniques and strategies described previously in section ii. It made me think that this kind of activity in the final session can be a useful way of distancing both patient and therapist from any emotional difficulties either may have with the end of the therapeutic relationship.

During discussion of relapse prevention the therapist may become involved, to guide the patient or make suggestions and give advice about how the patient may best cope with future relapse:

(Pt 24)

Th: you may also want to include medication, if you feel it has helped you in the past

I had the impression that advice giving was a further example of the therapist ‘giving the patient something to take away from therapy’. It was sometimes used to comfort, reassure and instill hope again in both types of therapy.

v. Expression of affect about ending therapy

This category includes a range of different feelings that can be experienced at the end of therapy. The most commonly expressed feelings about ending therapy were positive ‘healthy’ feelings, concern or worry and frustration. Concern about future relapse was mentioned in section iv. Predominant feelings experienced at the end of therapy are discussed in the quantitative results section 3.2.1.

It was my impression from qualitative analysis that the majority of feelings expressed were positive, although often there was some anxiety, or even fear that symptoms would return once therapy had ended:

Examples from IPT:

(Pt 3)

Pt: I haven’t been worried about finishing therapy. I’ve not felt anxious...

(Pt 1)

Pt: so at the moment I feel better, I don’t know, I suppose my fear is what happens if this rears its ugly head in a year, or 18 months, it scares me the thought of having it for life

At times frustration was expressed that therapy had not been enough:

An example from CBT:

Pt (15)

Pt: ... I can’t help feeling this 16 weeks is a course of antibiotics for the mind...as if trying to do too much in a short space of time

The category of patient expression of affect about ending therapy also included an item for ‘therapist encouraged / facilitated patient’s expression of affect about ending’.

An example from IPT:

(Pt 39)

Th: we're at number 16 today...it's going to be important for us to talk about how we feel about this being the last appointment.

It seemed that in IPT the therapist was more alert to how the patient felt about the end of therapy, either commenting on this at the very beginning of the session or in response to a range of different comments (e.g. implicit reference to ending, problematic termination reactions).

An example from CBT:

(Pt 24)

Th: how are you feeling about it being the last session?

Pt: a wee bit nervous about it but I do feel I might be able to cope with things

In contrast a similar facilitation of expression of feeling about ending therapy was present in CBT, but to a significantly lesser extent, as was described previously in section 3.2.2(v).

vi. Patient made implicit reference to end of therapy

This category is defined as the patient making reference during the session, to the loss of someone, or something; the end of a significant relationship in the past, present or future; and/or an awareness of the patient's own mortality. In conjunction with this item, there is also an item for whether the therapist acknowledges the implicit reference (to the end of therapy) and /or uses it to facilitate further discussion of the patient's feelings about termination; and a category for other.

In the following example taken from a final session of CBT with a female therapist, the male patient makes reference to the difficulty he has accepting the ending of a previous relationship:

(Pt 26)

Pt: I couldn't sleep last night, I woke up early this morning. Last night I was thinking about Elise (ex-girlfriend)....she's been in my head, since this dream, like all weekend...feeling nervous in the morning, like this morning...there's no reason for this....

Th: ok, ok, when did that start?

Pt: a week or two ago, I'm thinking there's just no reason for this, you know..

Th: ok. (pause). You've said you were feeling a bit more anxious?

(Patient talks about feeling anxious at a dinner party)

An interesting perspective on this excerpt relates to the patient's implicit reference to ending therapy and the difficulty he has expressing his anxiety about this. When the therapist pauses during the previous excerpt, there is a sense of her uncertainty about how to respond and I wondered whether she had considered the end of their relationship but was unsure how to discuss this with the patient. The therapist does not explicitly recognise what *could* be underlying his comments about a previous girlfriend, or finds it difficult to ask him how he feels about the end of their relationship. An overall comment on this session as a whole is that the patient repeatedly makes reference to several relationships that have ended badly. He cannot cope with the end of therapy and becomes preoccupied with having more therapy with another therapist. The reaction to termination is problematic raising a potential link between implicit references to ending therapy and difficulty coping with the termination of therapy.

An example from IPT:

(Pt 17)

Pt: Since seeing you last week, I was feeling really really down.....death has been a worry that's been going on for quite a while in the background, so I hadn't really thought about it much in the past two months, I didn't see it as a problem, but basically over the past few days it's a worry that's come back....it's really about whether when the time comes I'll be ready then or not..

Th: It sounds like quite an abstract worry...I wonder if you're able to place it in any context, if things are happening?

Pt: I did try and do that, but this is something that's external...it's beyond my control in a sense...it's just beyond my control. Eventually we'll all die and that's that.

Th: ...what's happening is you're getting further into the worry, and not looking outside of that, to say, now, what's changing? It strikes me that I wonder if it's entirely coincidental that that comes up at a time when this (therapy) is coming to an end?

In this excerpt the therapist acknowledges the patient's implicit reference to ending therapy and uses it to facilitate discussion about the termination process.

vii. Problematic termination reactions

In this category I did not observe any obvious, qualitative difference between CBT and IPT in terms of problematic termination reactions. The following excerpt provides an example of a patient's exacerbation of symptoms of depression in a final IPT session.

An example from IPT:

(Pt 30)

Pt: like I say I'm just on a bit of a downer today

Th: what's changed? What's going on that you feel like this?

Pt: I think things are pretty hopeless. That's my view of the current situation

Th: some weeks you're not as negative as this, I wonder what's happened?

Pt: I just don't feel I can achieve anything. It's just no good, I'm stagnating

Th: is it that today is ...er...our last regular session, we meet again in a month. Does it worry you that this is our last session?

Pt: you want me to be honest? Not really, cos it never done any good for me...no offence to you I just think I'm beyond help

In this excerpt the patient perhaps feels that the therapist is abandoning him and in response to this he may feel angry, frightened or depressed at the loss of the relationship. The therapist similarly seems to make a link between the patient's reaction and it being their last session, however when asked about this the patient responds with an angry defence. My understanding of problematic termination reactions are that they can evolve in response to the patient being unable to express their feelings about ending towards the therapist, as the previous example potentially highlights.

3.3.3 Summary

Qualitative analysis highlighted a number of observations regarding interactions between patient and therapist during termination of therapy. To summarise, these were discussion of the end of therapy in the context of the loss of a significant relationship; differences between CBT and IPT in terms of evaluative comments made; and an illustration of the celebratory tone evoked at times during termination in IPT. It also seemed that discussion of the future in both CBT and IPT was helpful in reassuring the patient, or encouraging feelings of hope for the future; and two contrasting examples were described of the patient making an implicit reference to the end of therapy and the therapist's response. A final observation was that a problematic termination reaction can arise due to the patient possibly being unable to express feelings about ending therapy.

In the following section quantitative and qualitative results are discussed in light of initial hypotheses made at the outset of this study.

4. Discussion

4.1 Introduction

The main purpose of this study was to compare two different types of therapy, Cognitive Behaviour Therapy (CBT) and Interpersonal Psychotherapy (IPT), on various components of termination activity. A quantitative approach was adopted to facilitate comparison of the two therapies and this was complimented by a qualitative approach to illustrate findings in more detail. Termination activity was defined by a coding scheme based on the Termination Behaviour Checklist –Therapist (TBC-T) (Quintana & Holahan, 1992). Various aims and hypotheses were generated to structure the investigation and this discussion will relate results of the study to these aims and hypotheses, and to the literature described in the introduction. Following this, limitations of the study will be discussed and areas of future possible research.

4.2 Discussion of hypotheses

4.4.1 Total termination activity

The first hypothesis, that there would be a greater amount of total termination activity in final sessions of Interpersonal Therapy (IPT), in comparison to final sessions of Cognitive Behaviour Therapy (CBT) was supported. This finding could be attributed to the emphasis placed on the termination phase of therapy in IPT, in comparison to CBT. Interpersonal Psychotherapy identifies tasks of termination as: discussion of the end of therapy; acknowledgment of how this might feel for the patient; and recognition of individual competence as a result of therapy, reviewing changes and looking to future life after therapy (Weissman et al., 2000). Whereas CBT suggests patient and therapist consider what has been learned from therapy in terms of relapse prevention (Hawton et

al., 1989; Jarrett et al., 2001). The present study has explored this difference in more detail as will be described in section 4.2.2.

4.2.2 A comparison of the categories of termination

The second hypothesis made more specific predictions about how IPT would differ from CBT on particular aspects of termination behaviour. Findings will be discussed in sections i to vii.

i. Discussion of the end of therapy

In this investigation it was hypothesised that in the final sessions of IPT, there would be a greater discussion of the end of therapy, when compared with CBT, as a result of the more explicit termination phase of therapy in IPT. This hypothesis was not supported for the summary variable, 'discussion of the end of therapy'. A possible explanation of this finding is the relatively small presence of this as a termination category in general (six percent of total termination activity). Of the items that were included in the comparative analysis, only 'therapist mentions the end of therapy' was normally distributed. It was the most common item in the category across both types of therapy. This finding suggests that in both types of therapy it is the therapist, rather than the patient, who is most aware of the end of therapy, or alternatively is more comfortable explicitly mentioning this. Statistical analysis showed that in IPT the therapist was significantly more likely to mention the end of therapy, than in CBT. This is supportive of an idea that more explicit awareness of the end of therapy is provided in IPT training (Weissman et al., 2000).

The item 'patient wanted to extend therapy' was relatively absent across the sample. An important factor in this observation is the patient's awareness at the outset of the study, that they were being offered a specific number of sessions as part of a research

investigation and were therefore potentially inhibited from asking for more sessions. This item may therefore be more present in a 'real' context of therapy, in which therapists are not always so rigid about the number of sessions they offer patients. Marx & Gelso (1987) report that often patients end therapy with an awareness that they can return at a later stage (Kramer, 1986; Quintana & Holahan, 1992).

In only a small number of IPT sessions and in none of the CBT sessions analysed, did the researcher categorise the end of therapy as being used to process the patient's experience of loss. This finding is interesting particularly in light of literature highlighted in the introduction to this study, describing the end of therapy as potentially evoking painful feelings associated with the loss of an attachment figure (Balint, 1950; Bowlby, 1969; Orgel, 1999). Miller et al., (1994) suggest that in short term therapy, as opposed to therapy lasting 6 months or longer, the end of therapy is less emotionally upsetting or traumatic, and termination is not always a significant phase of therapy (Sifneos, 1972). Alternatively the patient may feel less able to mention the sadness they feel at losing the therapist in short term therapy, which would explain expression of loss as being less evident. An explanation of this finding could also be the strict definition used, for 'using the end of therapy' to explore the patient's experience of previous loss. On reflection this item might have been more broadly defined in terms of 'during the end of therapy the patient processed previous loss experiences'.

Qualitative analysis revealed an instance in IPT, which highlighted the therapist persuasively and reassuringly reframing the patient's sadness in terms of their recent loss, which coincided with the end of therapy. This helped reduce the patient's fear that her sadness was returning symptoms of depression. Marx & Gelso (1987) report that there is

a greater amount of termination activity, when loss has been a theme in therapy. This would have been an interesting aspect of termination to explore, although in the current study there were so few examples in which it was easy to identify what had been the theme of therapy, this was not possible. An interesting future avenue of investigation would be to look at the termination phase of IPT in which the focus of sessions was loss (see Miller et al. 1994).

ii. Evaluation of therapy

It was predicted that final sessions of IPT would have a significantly greater amount of evaluation of therapy, when compared with CBT. This finding was supported in the present sample.

Evaluation of therapy was observed as the predominant termination activity in the sample, contributing to approximately half of total termination activity. In terms of the predominance of items within the category, frequency distributions suggest that the patient's expression of things they either liked or disliked about therapy, was not frequently observed, in comparison with summarising the work (patient or therapist) and assessing attainment of goals. This finding supports literature on management of the end of therapy, which describes the process of reviewing therapy, as a common aspect of the final therapy sessions (Bywaters, 1975; Penn, 1990; Ward, 1984).

The quantitative difference between CBT and IPT, IPT having a greater amount of evaluation of therapy, coincides with the theoretical emphasis placed on this activity in IPT as a task of termination. However in CBT this activity was still quite evident and reflects literature describing how CBT therapists should manage the end of CBT with patients (Hawton et al., 1989; Jarrett et al., 2001). Quintana & Holahan (1992) reported

that in cases in which the therapist perceived greater success, there was more termination activity. If evaluation of therapy is the predominant activity, as was the case in this study, it makes sense that this would happen more often in cases in which there has been some perceived improvement, as opposed to those in which the patient had made fewer gains, where it might be more difficult to openly discuss dissatisfaction with therapy. This suggestion is considered in the third hypothesis of the study (section 4.2.3).

Qualitative analysis highlighted some differences between the respective types of therapy regarding the evaluative process. Whilst in IPT it was observed that evaluative comments were descriptive of changes in relationships, in CBT there was more of an emphasis on discussion of new activities, changed behaviour and managing negative thoughts. This may reflect the overall theoretical focus of each type of therapy as described in the introduction section to this study (Beck et al., 1979; Weissman et al., 2000).

In this study Cognitive Behaviour Therapy was also described metaphorically by some patients; like a 'game of tennis', or a 'mechanic selecting tools'. The emphasis was on therapy as a learning process in which skills and techniques to 'combat' distress are taught. These findings support research on the non-specific benefits of therapy expressed by patients, unrelated to the type of therapy undertaken; for example an expectation of receiving help and success in therapy, hope, and a greater sense of self efficacy (Butcher & Koss, 1978; Murray & Jacobsen, 1978; Shapiro & Morris, 1978). Weishaar (1993) also describes this as a common criticism of CBT, that it is 'a simplistic set of techniques' (Weishaar, 1993, p. 108).

iii. Closure of the therapeutic relationship

Overall this activity did not occur frequently in the sample (six percent of termination activity) and as qualitative analysis highlighted, often final sessions ended due to time having run out. The most common expression of closure (apart from the item 'other') was for the patient to thank the therapist.

It was predicted that there would be a significant difference between CBT and IPT in terms of closure of the therapeutic relationship and that there would be greater closure of the therapeutic relationship in IPT. Statistical analysis showed that there was a significantly greater amount of closure of the therapeutic relationship in final sessions of IPT compared to CBT.

The difference in amount of closure of the therapeutic relationship between the two therapies can partly be explained by the observation that in IPT, the end of therapy was sometimes viewed by the therapist as a graduation, or celebration. Comments of this type were coded 'other', explaining the relative prevalence of this item in the category. The ending as a 'graduation' from a state of illness, is a distinctive aspect of IPT (Markowitz, Svartberg & Swartz, 1997). This coincides with the medical view that the patient is given the 'sick role' in IPT and has an obligation to work with the therapist in order to alleviate symptoms of illness by the end of therapy.

An example was described in CBT, in which the awkwardness of closing the therapeutic relationship seems to lead a patient to make a personal comment about the therapist at the end of the final therapy session. Although this was not a frequent occurrence in this sample, it led the researcher to consider the patient's difficulty in maintaining boundaries as the therapeutic relationship comes to an end. One possible explanation is that the

sadness, anxiety, or pain associated with the ending of a relationship that has been significant, provokes the patient to seek a way of maintaining the relationship outside of therapy, perhaps as a defence against the reality of the loss.

No instance was observed in which the patient wanted to mark the end of therapy. This item, included in the Termination Behaviour Checklist – Therapist, has also not been described in literature on the end of individual therapy. Shapiro & Ginzberg (2002) describe the importance of patients in group psychotherapy, marking their leaving of the group to help them achieve a more clearly defined sense of self. Potentially this type of behaviour is more likely to occur in longer term psychotherapy, in which the decision to leave is initiated by the patient as opposed to the ending being imposed by external factors such as a time limit, as was the case in the present investigation.

iv. Discussion about the patient's plans for the future

There was no significant difference between CBT and IPT in terms of amount of discussion about the patient's plans for the future. This was in contradiction to the hypothesis that in IPT this would be observed more frequently.

Discussion about future plans was a relatively common termination activity in the sample (twenty two percent of termination activity). The most frequently observed items were discussion about the patient's future plans and discussion of relapse prevention. This reflects an emphasis in both IPT and CBT on facilitating discussion about the future, in particular in terms of maintaining the benefits of therapy (Hawton et al., 1989; Jarrett et al., 2001; Markowitz et al., 1997). A consideration of relapse prevention seems to compliment the process of evaluating what has been useful in therapy, in order to maintain the benefits of therapy into the future. This would explain the finding that both

evaluation of therapy and discussion of the patient's future, were predominant termination activities in the sample of sessions analysed.

Qualitative analysis highlighted the practical nature of discussing relapse prevention. An excerpt is described from a CBT final session, in which the therapist encourages the patient to make a list of what they might put into practise, in order to prevent their symptoms returning, or to help them cope should they relapse in the future. This practical gesture seems to coincide with Orgel's (2000) suggestion that in psychoanalysis, the aim is for something of the analytic stance to have been internalised, in order that it will stay with the patient after termination. Similarly discussion of relapse prevention is an exercise that confirms what the patient will take from therapy, to use in the future should symptoms return.

Discussion of future plans also included more general discussion of engagement in new activities, relationships or challenges. These are viewed as constructive activities outside of the therapeutic relationship (Flapan & Fenchel, 1987; Fortune et al., 1992). Qualitative analysis revealed an instance in which this task was given a practical emphasis in CBT, whilst also highlighting it being used as a technique of reassurance in IPT, to encourage hope for the future. This kind of activity reflects the stage of 'testing' described in Hopson & Adam's (1976) theory of transition. Similarly Parkes (1975) describes a phase in the process of grief, in which the bereaved person invests in new challenges, becoming active and involved in life. The creation of a new identity is viewed as an important aspect of this process. Similarly therapeutic change might be perceived by patients as similar to the process of creating a new identity following therapy. Although this was not

an explicit finding in this study, it might be observed in a more explorative, qualitative approach to analysis of termination.

In this study the therapist infrequently suggested other types of help, and the patient rarely expressed wanting an opportunity for future contact with the therapist. This may be another consequence of patients being informed at the outset that they were being offered a limited number of sessions as part of a research investigation. An indirect effect of this may have been that patients were less likely to ask for further contact and the therapist was less likely to suggest other types of help.

v. Expression of affect about the end of therapy

A small percentage (six percent) of termination activity was spent discussing how the patient feels about ending therapy. The current study found that patients mentioned a mixture of both positive and negative emotions at the end of therapy. The most commonly expressed feelings about ending therapy were positive 'healthy' feelings, concern or worry, and frustration. It was the researcher's impression from qualitative analysis, that in the majority of cases there were healthy feelings of pride and hope for the future, alongside some anxiety or concern that symptoms would return once therapy had ended. It seemed that frustration during termination was expressed when it was perceived by the patient that therapy had not been enough, or that skills learned were superficial and not addressing the 'root' of the problem. This supports empirical research on termination which suggests that termination of therapy involves a range of both positive and negative emotions (Gelso & Woodhouse, 2002; Roe et al., 2006).

It was predicted that in final sessions of IPT there would be a significantly greater amount of expression of affect about ending therapy, when compared with CBT, and this

hypothesis was supported. In fact the difference between therapies on this category of termination activity was found to be highly significant. An interesting additional finding was that there was a significant difference between the therapies in terms of the therapist's facilitation of affect about ending therapy. IPT therapists were significantly more likely to ask the patient how they feel about ending therapy, in comparison to CBT therapists.

The finding that CBT therapists were significantly less likely to facilitate expression of affect about the end of therapy is interesting, particularly so given the significant amount of literature emphasising the importance of the therapeutic alliance (relationship) in contributing to therapeutic outcome (Horvath & Symonds, 1991). Reduced attendance to feelings about the end of the relationship could be considered, from a cognitive perspective, as minimising the importance of identifying emotions and their associated cognitions, as Beck and his colleagues suggested (Beck et al., 1979). Writers from a psychodynamic perspective have also suggested that management of termination can have a significant impact on longer term therapeutic outcome. Therefore, to pay reduced attention to how a patient feels about the ending could be a significant factor in how the patient manages the end of the therapeutic relationship (Levinson, 1977; Yalom, 1977). Martin & Schurtman (1985) describe how termination anxiety on behalf of the therapist can interfere with managing the end of therapy with a patient. This raises the possibility that the explicit framework of a termination phase in IPT reduces anxiety in the therapist about the end of therapy. In CBT, the relative absence of a similar framework, particularly with reference to the emotional impact of the ending, may leave the therapist feeling unsure of how to facilitate the patient's expression of feeling about the ending.

vi. Patient made implicit reference to the end of therapy

This additional category was included in the coding scheme, having listened to final therapy sessions as part of an initial pilot study. It was also influenced by a psychodynamic perspective in which unconscious communication from the patient is interpreted (Casement, 1985; Penn 1990). In this context, when a patient mentions for example, a previous relationship that ended leaving the patient feeling anxious and angry, this can be interpreted as potentially indicating some difficulty managing feelings about the ending of the therapeutic relationship. Having been repressed, difficult feelings emerge in a disguised form, for example in dreams, slips of the tongue, or the memory of a previous relationship. Malan (1979) suggests that there is a compromise between the wish to conceal and the wish to reveal, so that the communication is disguised.

Qualitative analysis described examples of the patient making implicit references to the end of therapy in both CBT and IPT. Quantitative analysis did not reveal a significant difference between therapies in the frequency of references made, however descriptive statistics highlighted a greater overall mean amount of references made in CBT. There is a possibility that the reduced amount of explicit termination activity in CBT influences the patient's likelihood to make implicit references to the ending of therapy, although this was not investigated and is a very tentative suggestion given that the difference between therapies is not significant. Beach & Power (1996) found that transference references during cognitive behaviour therapy did not lessen if they were not acknowledged or recognised. This raises the possibility that implicit references to the end of therapy similarly do not lessen, if not recognised.

The finding that patients make what might be understood as implicit references to the end of therapy has been explained from a psychodynamic perspective; difficult feelings are repressed and communicated unconsciously (Casement, 1985; Malan, 1979; Penn, 1990). An alternative explanation of the implicit references made, might be that the patient has some conscious (or unconscious) awareness that the therapist might not be able to cope if the patient expresses strong feelings at the end of therapy. A consequence of this could be that the patient 'looks after' the therapist and presents some of their distress in this disguised, implicit way. The example described in the results section in which a male patient, anxiously describes being disturbed by thoughts of previous girlfriends, might be understood in this way. If this is the case it has important implications for the therapeutic process and highlights an awareness that might be incorporated into clinical practice. Additionally it potentially also suggests an area of future research.

In terms of the therapist acknowledging the implicit reference made, in IPT this happened on average more often than in CBT and statistical analysis revealed this difference to be significant. This may relate to a greater awareness in IPT of the ending of therapy, which potentially results in this being more readily and explicitly acknowledged. In addition Markowitz et al. (1997) suggest that IPT therapists often have a background training in psychodynamic psychotherapy and therefore are perhaps more likely to attend to aspects of unconscious communication, or what is happening in the therapeutic relationship.

vii. Problematic termination reaction

Problematic termination reactions were observed in a small proportion of the sample, representing less than six per cent of total termination activity. An item in this category that was particularly difficult to categorise, was 'patient idealising therapy or the

therapist'. It was the researcher's impression that although this may have been the attitude of some patients towards their therapist, it was difficult to identify the verbal expression of this when listening to taped sessions.

No significant difference between CBT and IPT in terms of problematic termination reactions was found. Baum (2005) defines problematic reactions as holding behaviours; such as raising new problems, or an exacerbation of previous symptoms. This can be understood as indirect communication from the patient that they do not want to end therapy. Baum (2005) found that reduced client control in the termination process, perceived centrality of the therapeutic relationship and the more the patient felt therapy had been unsuccessful, was associated with greater problematic termination behaviours. Although these variables were not measured in the current study, the relatively low level of problematic termination responses suggests patients were perhaps not influenced by these variables at the end of therapy.

Overall in CBT there was a greater mean amount of problematic termination reactions, in comparison to IPT. A potential explanation of this is that the relatively reduced amount of termination activity found in CBT is associated with problematic termination responses.

Analysis of the relationship between termination activity and problematic termination behaviours, found a significant, negative correlation between the two variables, although this finding is interpreted tentatively, as a scatterplot indicated that the correlation was influenced by a small number of extreme scores. If the finding that there is a relationship between the two is contemplated, it suggests that for those patients who find it difficult to end therapy, there is a reduced amount of termination activity, which corresponds with

Quintana & Holahan's (1992) finding that in less successful counselling cases, there tends to be reduced termination activity. This raises the possibility that less successful cases have more difficulty ending therapy, potentially due to them not having found therapy of benefit. The following section explores the relationship found in this sample, between amount of termination activity and reduction in symptoms of depression and anxiety.

4.2.3 Termination and outcome

The third hypothesis sought to correlate termination activity with outcome of therapy, as measured by change in level of depression and anxiety during therapy. This hypothesis was derived from Quintana & Holahan's (1992) findings that amount of termination activity was positively associated with the therapist's perceived successfulness of therapy.

A significant moderate positive correlation was found between an improvement in symptoms of depression and total termination activity. This finding should be interpreted tentatively. The implication is not that improved symptoms are a direct result of the amount of termination activity which would not account for the effectiveness of the particular therapy. Additionally proof of causality in correlations between psychotherapy process variables and measures of outcome is difficult to demonstrate (Garfield, 1990). However the suggestion is that there is a relationship between reduced symptoms of depression and termination activity. An explanation of this would be that if the individual feels less depressed, they may, for example, be more likely to participate in evaluation of therapy, (the predominant termination activity in this sample), express positive feelings, thank the therapist and discuss the future in a positive light. As mentioned previously,

evaluation of therapy as the predominant termination activity across the sample would perhaps be a less comfortable activity, and therefore less evident in the sample, if patients did not feel they had made any progress in therapy. It could also be considered that amount of termination activity is representative of the depth of the overall therapeutic relationship, therefore having an indirect effect on symptoms of depression, via the therapeutic relationship.

Results however did not find a significant relationship between a reduction in anxiety symptoms and amount of termination activity. This suggests that the end of therapy may be more significant for patients who are depressed, taking into consideration the importance of the experience of loss for people who are depressed (Beck, 1967; Freud, 1915). Alternatively patients were not identified by diagnosis in this study, which therefore raises the possibility that patients were both anxious and depressed, with depressive symptoms being the predominant concern for patients attending therapy.

This study has used outcome measures based on standardised questionnaires for symptoms of depression and anxiety, to investigate change in symptoms over the course of CBT and IPT. However content analysis of data has also provided information on outcome of therapy. The high predominance of evaluation of therapy as a termination activity indicates that patients are open to discussing the changes and benefits they have noticed as a result of attending therapy. Several clinical examples were described in which patients refer to CBT as a learning process, indicating their understanding of this approach as providing skills and strategies to challenge distress. In terms of expression of feelings about termination, although generally this was a relatively rare occurrence, a

significant number of patients expressed feeling healthy about the ending, as if they are ready to cope independently.

In contrast a small proportion of the sample experienced problematic termination responses. Such responses could be said to reflect a reduced therapeutic outcome. An interesting observation is that the case described to illustrate problematic termination reaction in results section 3.3.2 (vii), scored as the most depressed in the sample at the end of therapy and was also shown as an outlier in terms of a significant amount of problematic termination responses. This patient devalued therapy and also expressed an exacerbation of symptoms at the end of therapy, indicating what might be a broader, unexplored relationship between symptoms of depression and a problematic termination reaction.

4.3 Limitations of the study

This study has compared termination in final therapy sessions, a small percentage of which were penultimate sessions. In order to fully analyse termination as a phase of therapy, earlier sessions would also have been analysed. This would be important for a fuller assessment of whether termination activity is exclusive to final sessions and at what stage during therapy the termination phase begins.

A major goal of the scientific method underpinning content analysis is to investigate hypotheses, aiming to avoid the bias and subjectivity of the researcher. In content analysis this is an important principle, differentiating it from qualitative methods of analysis, where the subjective position of the researcher is acknowledged as part of the investigation (Chenail & Maione, 1997; Neuendorf, 2002). In this study the researcher was not blind to the therapy session being coded at a particular time and as a therapist,

their understanding of the termination process inevitably would influence coding. A measure of inter rater reliability was employed to limit the extent to which the bias of the researcher would influence data analysis.

An important limitation in using a coding scheme to categorise data, which would be overcome by a qualitative method of analysis, is that excerpts, although having some meaning in themselves, have been removed from the context from which they originated i.e. a therapy session between patient and therapist. The context is relevant both to understanding what is going on, and to validating any claims made as consequence of analysis (Mason, 1994). This is an important drawback of content analysis; that the endeavour to convert qualitative data into quantitative data has the inevitable consequence that something of the meaning is lost.

There were losses in not having a complete record of each session transcribed, for easy coding. However there were perhaps gains in that the repeated listening which this method required did perhaps reveal what might have been unnoticed recurring patterns.

This study used a coding scheme derived from a termination behaviour checklist (Quintana & Holahan, 1992) to measure amount of discussion of termination in sessions. Findings indicated a high proportion of sessions in which particular behaviours did not occur, which raises questions regarding the validity of the coding scheme, or whether this is an artefact of the therapies being investigated. The aim of this study was not to validate the coding scheme, however a larger sample size might have yielded results in which variables were not so positively skewed.

4.4 Areas of future research

Content analysis was used in this study to generate quantitative data from therapy sessions regarding termination. A more explorative investigation, with the aim of investigating the process of termination of therapy could have been carried out using a qualitative approach such as grounded theory (Bryman & Burgess 1994). As mentioned previously this might have led to the generation of themes that were undefined in the structure of the coding scheme.

Future work might also investigate variables not measured in this study, but of importance in the experience of the termination phase of therapy. Personality, attachment style, loss history and stage of life have all been suggested as potential variables influencing the patient's experience of the end of therapy (Gelso & Woodhouse, 2002; Marx & Gelso, 1987; Miller et al., 1994). It would have been interesting to correlate amount of termination activity with loss when featured as a focus of IPT. Due to the small sample size and difficulty identifying from final sessions what had been the focus of therapy, this was not carried out in the current investigation although it was initially considered.

Authors from a psychodynamic perspective have suggested that the longer term outcome of patients following psychotherapy is reliant on the way in which the termination phase of therapy is managed (Levinson, 1977; Ward, 1984; Yalom, 1975). A possible avenue for further research, as an extension of the current study, is whether amount of termination activity in CBT and IPT is associated with longer term maintenance of therapeutic outcome. A similar investigation could also look at the degree to which overt termination behaviour, relates to covert, implicit references to termination made during

latter therapy sessions; or how termination activity relates to the strength of the therapeutic relationship.

It might also be of interest to explore how therapists in CBT and IPT experience the end of therapy. In the evaluation of competencies for trainees, on the University of Edinburgh clinical psychology training course, trainees are assessed for their ability to:

‘negotiate and decide upon an appropriate end for therapy that is collaborative, constructive and productive for the client and others, and not perceived as abandonment. If appropriate relapse prevention strategies are utilised’ (Evaluation of clinical competence form, 2003)

The termination phase of therapy is clearly recognised as an important and necessary competency for those training as clinical psychologists. It is therefore surprising that so little literature on the topic exists, and potentially of importance that there is a significant difference between CBT and IPT in terms of attention paid to aspects of termination.

5. Conclusions

Termination activity in either cognitive behaviour therapy or interpersonal psychotherapy has not been the subject of investigation to date. The quantitative aim was to compare patterns in each therapy and a qualitative component of this was to reveal something of the processes and perspective of those actually involved in therapy. The finding that IPT, in comparison to CBT, pays greater overall attention to the ending of therapy during final therapy sessions is consistent with theoretical orientation, in that the end of the therapeutic relationship in an interpersonal approach is dealt with more explicitly than in a cognitive-behavioural approach.

In final therapy sessions of IPT, there was a significantly greater amount of evaluation of therapy, closure of the therapeutic relationship and greater patient expression of affect, in comparison to final sessions of CBT. IPT therapists were also significantly more likely to mention the end of therapy during a session, facilitate the patient's expression of feelings about termination and acknowledge an implicit reference made by the patient to the end of therapy. There was no significant difference between therapeutic interventions in terms of discussion of the patient's future which potentially reflects the emphasis given to relapse prevention in CBT.

The fact that patients make implicit references to the end of therapy in both CBT and IPT has raised the possibility of therapists being attentive to such references during termination.

Given the emphasis in the literature on the development of the therapeutic relationship in both CBT and IPT, attention to the ending of this relationship, in CBT in particular, is

comparatively minimal. An implication of this is that those being trained in CBT be made aware of the different ways in which the end of therapy can be facilitated.

In this study a significant, moderate positive correlation between a reduction in symptoms of depression and the amount of termination activity was found. Although proof of causality cannot be demonstrated, this potentially highlights the importance of attending to the ending phase of therapy when patients have experienced less therapeutic success.

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Appendix 1 – Thesis proposal



Doctorate in Clinical Psychology Thesis Research Proposal

Provisional Thesis Title: Termination in CBT and IPT

Trainee Name: Hannah Worthington

Proposed Thesis Project Supervisors

Clinical: Adam Burley (Roslyn Law for access to tapes)

Possible Academic 1 Mick Power

Possible Academic 2

Other (if applicable)

Proposed setting: University of Edinburgh
(Where research will be carried out)

Anticipated Month & Year of Submission of Thesis: 1st August 1st February
(please circle)

2005 2006 2007 2008 2009 2010

(Must be in final year for full time trainees. For flexible trainees, the month & year of submission will depend on their Individual Training and Development Plan)

Please Note: Most of the questions in this research proposal form are deliberately identical to questions contained in the new NHS Research Ethics form. The corresponding ethics form question numbers are given in parentheses. Thus if the proposal is satisfactory, answers completed here may be pasted directly into the ethics forms.

Version (date): October 2005

BACKGROUND

1) What is the scientific justification for the research? What is the background? Why is this an area of importance? (Must be in Language comprehensible to a lay person.) (Ethics A9)

The process of psychological therapy, what actually happens in therapy, is an area of research that is fundamental to the discovery of what makes it worthwhile and effective. The present research aims to investigate how the ending of psychological therapy, or 'termination phase', is managed. Research suggests that the ending of therapy may be a difficult time for clients and therefore it makes sense to approach termination sensitively. Many patients may have had some difficulty coming to terms with loss in their life and therefore versions of a 'termination as loss' model have been around for several decades (Balint, 1950). However this model has been questioned. Quintana (1993) examines the loss metaphor and suggests that the model be updated and termination be viewed as 'transformation', not necessarily a time of crisis, but a time for potential development.

Four components of termination have been identified from literature (Lamb, 1985); discussion of the ending, review of the course of counselling, closure of the therapeutic relationship and discussion of the client's future plans. Different types of therapy, such as cognitive behavioural therapy (CBT) and interpersonal therapy (IPT), place a different emphasis on the handling of termination. To date little research has been carried out investigating how CBT and IPT therapists manage termination. The majority of research has been carried out with counselling and psychodynamic therapists (Quintana & Holahan, 1992). Quintana & Holahan (1992) suggest that the perceived successfulness of therapy has an impact on how termination is approached with 'unsuccessful cases' having reduced 'termination activity'.

2) Aims, hypotheses and/or research questions

(Keep these focused and concise. Maximum of 5 hypotheses)

1. How do CBT and IPT therapists approach the termination phase of therapy?

- A) What are the commonalities and/or differences between these approaches?

Comparisons will be made according to components of termination discussed above: – discussion of ending; review of course of therapy; closure of therapeutic relationship; discussion of client's future plans.

The termination behaviour checklist (Marx & Gelso, 1987) will be used as a structured tool to assess termination activity.

- B) Does whether the therapy has been successful have an impact on how therapy is managed?

Successfulness of therapy can be measured according to BDI scores taken during the course of therapy – arguably a change in BDI score, might correlate with termination activity, measured using the termination behaviour checklist.

PLAN OF INVESTIGATION

1) Give a brief synopsis/summary of methods and overview of the planned research. (Adapted from Ethics A10 & C6)

Taped sessions of IPT and CBT will be transcribed and analysed in order to identify aspects of the termination process as discussed. These tapes are already available from an RCT carried out previously, comparing CBT and IPT.

The data will be assessed qualitatively in order to identify common emerging themes.

The termination behaviour checklist (Marx & Gelso, 1987) will also be used as a structured tool to aid description of the termination process. Comparison between scores on this checklist will enable data to be assessed quantitatively.

The BDI (Beck Depression Inventory) will be used as a measure of how successful therapy has been, which can then be correlated with scores on the termination behaviour checklist.

2) How will potential research participants in the study be (i) identified, (ii) approached and (iii) recruited? (Ethics A20)

Give details for cases and controls separately if appropriate:

- i) Therapy sessions will be selected for analysis depending on whether termination activity can be identified. Termination activity is defined as sessions in which the end of the therapeutic relationship is discussed.
- ii) Approached – taped therapy sessions have already been collected for research purposes. At the time participants were asked to consent to the data being used for training and research purposes in the future.
- iii) Recruited – Participants were GP referrals (inclusion/exclusion criteria)

3) What are the principal inclusion and exclusion criteria? (Ethics A22 & A23)

Inclusion criteria for analysis of the termination process are therapy cases in which there is termination activity to be transcribed, or to be recorded in terms of termination behaviour.

Exclusion criteria will be recordings of poor quality that cannot be transcribed adequately. Clients who did not complete therapy (drop out), and therefore did not reach an agreed termination session / phase, will also be excluded.

4) How will data be collected?

If quantitative, list proposed measures and reason for inclusion. If qualitative, explain how data will be collected giving reasonable detail (don't just say 'by interviews')

Therapy sessions have been recorded and will be listened to first to ensure the quality of recording is adequate. Sessions to be analysed will be transcribed for further analysis.

A number of outcome measures were collected during the initial phase of the research process. The BDI was completed by the client in every session, although in reality there is data missing as this was not achieved consistently. The BDI is a measure of depression and can be used to assess the extent to which the therapeutic process is successful.

5) Has the size of the study been informed by a formal statistical power calculation?

If so, indicate the basis upon which this was done, giving sufficient information to allow the replication of the calculation: (Ethics A51)

Yes – the RCT included power calculations based on outcome measures

6) Plan for dissemination of results

How will the results of research be made available to research participants and communities from which they are drawn? (Ethics A38)

Thesis (and publication?)

7) What is the expected total duration of participation in the study for each participant?
(Ethics A15)

Already completed

8) What do you consider to be the main ethical issues or problems that may arise with the proposed study, and what steps will be taken to address these? (Ethics A68)

(Include 'Patient Information Sheet' and 'Consent Forms' as Appendix where applicable).

Ethical concerns regarding the nature of the research – listening to confidential information, particularly regarding ending therapy, which may bring about issues related to loss, grief and other distressing personal experiences.

Consent forms were given to participants to ensure their understanding of the nature of the research and anonymity.

9) Will participants include any of the following groups? (Derived from Ethics A24)

| | | | | |
|-----|---|-----|---|-----------|
| 1. | Children under 16 years | Yes | / | <u>No</u> |
| 2. | Adults with learning disabilities | Yes | / | <u>No</u> |
| 3. | Adults who are unconscious or very severely ill | Yes | / | <u>No</u> |
| 4. | Adults in emergency situations | Yes | / | <u>No</u> |
| 5. | Adults with mental illness | Yes | / | <u>No</u> |
| 6. | Adults with dementia | Yes | / | <u>No</u> |
| 7. | Prisoners or Young offenders | Yes | / | <u>No</u> |
| 8. | Adults who are unable to give consent | Yes | / | <u>No</u> |
| 9. | Healthy volunteers | Yes | / | <u>No</u> |
| 10. | Individuals who could be considered to have a particularly dependent relationship with investigator | Yes | / | <u>No</u> |
| 11. | Other vulnerable groups | Yes | / | <u>No</u> |

If "Yes" to any of the above, please justify their inclusion:

Other Ethical Issues

| | | | | | | |
|----|--|------------|---|-----------|---|-------------|
| 1. | Will feedback/debriefing be provided | Yes | / | No | / | <u>N.A.</u> |
| 2. | Will subjects have the right to withdraw | Yes | / | No* | / | <u>N.A.</u> |
| 3. | Will records remain confidential | <u>Yes</u> | / | No* | / | N.A. |
| 4. | Will anonymity be ensured | <u>Yes</u> | / | No* | / | N.A. |
| 5. | Will the study involve 'deception' | Yes* | / | <u>No</u> | / | N.A. |
| 6. | Will invasive procedures be included | Yes* | / | <u>No</u> | / | N.A. |

If "*" to any of above, please outline why

Appendix 2 – Confirmation of ethical approval



Lauriston Place
Edinburgh EH3 9YW
Telephone 0131 536 1000
Fax 0131 536 1001

THE ROYAL INFIRMARY OF EDINBURGH

THE
ROYAL
INFIRMARY
OF EDINBURGH
TRUST

CHIEF EXECUTIVE

John J Owens BSc, DMS, MBA

Professor Mick Power
Department of Psychiatry
Kennedy Tower
Royal Edinburgh Hospital
Edinburgh

GM/ASM
11th September 1997
Psychological Medicine
Tel: 536 2875
Fax: 536 3408

Dear Mick

25/97

Brief structured psychotherapies for neurotic disorders in primary care

Thanks for your reply which was discussed at our September meeting. Your response clarified the uncertainties and resolved the anxieties our committee had about your proposal and I am pleased to confirm ethical approval without further qualification.

Best wishes.

Yours sincerely

DR G MASTERTON
CHAIRMAN
RESEARCH ETHICS SUBCOMMITTEE
(PSYCHIATRY & CLINICAL PSYCHOLOGY)

c.c. Dr C Freeman, Consultant Psychiatrist, The Cottage, REH.



Appendix 3a – Termination Behaviour Checklist – Therapist

Discussion of the end of counseling

Mutually decided when to end therapy

A final date was set

Therapy ended for external reasons

You tapered off the frequency of sessions

The end was a significant event in counseling

Used the end to process client's experiences of loss

Client wanted to extend length of counseling

You recommended therapy end early

Review of counseling and goal attainment

You summarized the work

Assessed the extent to which goals had been attained

Client stated things he/she liked about counseling

Client stated things he/she disliked about counseling

Client asked questions about how counseling works

Closure in the counselor-client relationship

Client thanked you

You shared feelings about therapy with client

You hugged or shook hands with client

You talked more about yourself

You and client relating more like equals than in past

Client asked personal questions about you

Client gave gift(s) to you

Discussion of plans for the future

You discussed client's plans for the future

You invited client to return to counseling

You suggested other types of help for client

Client wanted opportunity for future contact with you

Client plans to receive more counseling in future

Client expression of affect about the end of counseling

Client shared feelings about ending

Client expressed feeling healthy

Client expressed pride

Client expressed feeling calm

Client expressed concern

Client expressed frustration

Client expressed feeling afraid

Client experienced a sense of significant loss

Client expressed feeling alone

Problematic termination reactions

During termination client raised new problems

Client wanted to extend length of counseling

Client devalued therapy

Client idealized you and/or therapy

Appendix 3b – Termination Behaviour Checklist

Item

You thanking the counselor
Summarizing the work
Assessing how much goals had been attained
Discussing your plans for the future
Counselor sharing his/her feeling about ending the work
Setting a date for the final session
You sharing your feelings about ending with the counselor
Counselor inviting you to return if you feel the need
You and counselor hugging or shaking hands
You stating things about your counseling that you liked and disliked
You feeling like you and your counselor were relating more like equals than you had at earlier times
Counselor suggesting other types of help or other places to get help
You asking counselor personal questions about him/her
Counselor talking more about him/herself
Tapering off the frequency of sessions
You asking counselor questions about how counseling works
Other (client specified)
You giving a gift to the counselor

Appendix 4 – Coding scheme

| <u>Termination component / item</u> | Occurrence Record number of data unit (derived from tape counter transcription) |
|---|--|
| Discussion of the end of therapy | |
| The end was a significant event in therapy | |
| The end was used to process patient's experience of loss | |
| Patient wanted to extend length of therapy | |
| Therapist mentions ending therapy Or comments session being last (or last but one) | |
| Patient mention ending therapy Or comments session being last (or last but one) | |
| Other | |
| Evaluation of therapy | |
| Therapist summarised the work; (changes noticed/ what learned) | |
| Patient summarised the work; changes made/noticed, what learned | |
| Patient and therapist assessed the extent to which goals had been attained | |
| Patient stated things he/she liked about therapy | |
| Patient stated things he/she disliked about therapy | |
| Patient asked questions about how therapy works | |
| Other (e.g. therapist asks patient to evaluate therapy) | |
| Closure in the therapist-patient relationship | |
| Patient thanked the therapist | |

| | |
|---|--|
| | |
| Therapist thanked the patient | |
| Therapist shared feelings about therapy with patient | |
| Patient asked personal questions about therapist | |
| Patient gave gift to therapist | |
| Patient wanted to mark the end of therapy | |
| other | |
| Discussion of plans for the future | |
| Therapist and patient discussed patient's plans for the future | |
| Therapist suggested other types of help for patient | |
| Patient wanted opportunity for future contact with therapist | |
| Patient plans to receive more therapy in the future | |
| Therapist commented on relapse / relapse prevention Includes therapist giving advice to patient about relapse prevention | |
| Patient commented on relapse / relapse prevention | |
| Other | |
| Patient expression of affect about the end of therapy | |
| Patient shared feelings about ending therapy | |
| Patient expressed feeling healthy about ending therapy | |

| | |
|--|--|
| | |
| Patient expressed pride (<i>accomplishment, independence</i>) | |
| Patient expressed feeling calm | |
| Patient expressed concern (<i>apprehension, worry</i>) | |
| Patient expressed frustration | |
| Patient expressed feeling afraid | |
| Patient experienced a sense of significant loss | |
| Patient expressed feeling alone | |
| Patient expressed feeling hopeless | |
| Patient denied feelings about the end of therapy | |
| Therapist encouraged/ facilitated patient's expression of affect about ending therapy | |
| other | |
| Patient made implicit reference to ending therapy | |
| Patient made an implicit reference to ending therapy (loss of someone or something, end of significant relationship- past/present/future - awareness of own mortality) | |
| Therapist acknowledges the implicit reference, and/or uses it to facilitate further discussion of the patient's feelings about ending therapy. | |
| other | |

| | |
|--|--|
| Problematic termination reactions | |
| Patient raised new problems | |
| Patient wanted to extend length of therapy | |
| Patient devalued therapist / therapy | |
| Patient idealized therapist / therapy | |
| Patient expressed exacerbation of existing / previous symptoms | |
| Other | |

Appendix 5 – Coding rules

Coding Rules

(NB for some categories coding will require the subjective opinion of the coder to make a judgement that something is happening.)

Where there is no definition of how to code, the sub-category is assumed to be self-explanatory.

| <u>Termination category / sub category</u> | <u>Definition of how to code</u> |
|---|---|
| Discussion of the end of therapy | |
| The end was a significant event in therapy | coded either as yes or no. Requires the subjective opinion of rater regarding the session as a whole. 'Significant event' was defined as either problematic/ meaningful/important to the patient. |
| The end was used to process patient's experience of loss | coded either as yes or no. Requires the subjective opinion of rater regarding the end of therapy as a whole. 'Process experience of loss' was defined as discussion during session of loss experiences, with an explicit recognition of the parallel between loss experiences and the end of therapy. Definition of loss referred to any loss experience, not specifically bereavement. |
| Patient wanted to extend the length of therapy Therapist mentions ending therapy | therapist makes a comment regarding therapy ending / session being last (or second last) session |
| Patient mentions ending therapy | patient makes a comment regarding therapy ending / session being last (or second last) session |
| Other | Any other comment that the rater recognises as being relevant to the category but is not applicable to the subcategories defined. |

Evaluation of therapy

Therapist summarised the work

any statement made by the therapist that refers to the progress of therapy. Includes changes the patient has made that the therapist has noticed, what the patient appears to have learned. Includes feedback of questionnaire scores, compared with beginning of therapy.

Patient summarised the work

any statement made by the patient that refers to the progress of therapy. Includes changes the patient has made, what they have learned, what they have found useful/helpful and what they have not found useful/helpful

Patient and therapist assessed the extent to goals had been attained

refers specifically to goals set during therapy that either have or have not been completed. Also included discussion of symptoms i.e whether they are still present (e.g. in response to standardised questionnaire).

Patient stated things he/she liked about therapy

excludes what patient has learned / found useful/helpful (see 'patient summarised the work')

Patient stated things she/he disliked about therapy

excludes what patient has not found useful or helpful (see 'patient summarised the work')

Patient asked questions about how therapy works

Other

Any other comment that the rater recognises as being relevant to the category but is not applicable to the subcategories defined. Includes therapist initiation of evaluation discussion and/or facilitative questions e.g. 'what do you feel you have learned from therapy?'

Closure in the therapist-patient relationship

Patient thanked the therapist

Therapist thanked the patient

Therapist shared feelings about therapy with patient

therapist expresses any feeling about the therapeutic encounter e.g. sadness at the end, or having enjoyed working with the patient.

Patient asked personal questions about the therapist

Patient gave gift to therapist

| | |
|---|---|
| Patient wanted to mark the end of therapy | refers to the patient wanting to do something to symbolise the end of therapy. |
| Other | Any other comment that the rater recognises as being relevant to the category but is not applicable to the subcategories defined. (e.g. therapist wishing the patient well for the future, congratulating the patient on the progress they have made) |

Discussion of plans for the future

| | |
|--|---|
| Therapist and patient discussed patient's for the future | does not include discussion of relapse prevention |
| Therapist suggested other types of help for patient | e.g. non therapy or different type of therapy (i.e not more of the same type of therapy) |
| Patient wanted opportunity for future contact with therapist | |
| Patient plans to receive more therapy in the future | |
| Therapist commented on relapse / relapse prevention | therapist asks the patient to think about how they might cope in the future should they become anxious / depressed again; or gives the patient advice regarding relapse prevention. |
| Patient commented on relapse / relapse prevention | patient initiates / responds to the therapist regarding the possibility that they become anxious / depressed again |
| Other | Any other comment that the rater recognises as being relevant to the category but is not applicable to the subcategories defined. |

Patient expression of affect about the end of therapy

| | |
|---|---|
| Patient shared feelings about ending therapy | |
| Patient expressed feeling healthy | |
| Patient expressed pride | Including sense of independence, accomplishment |
| Patient expressed feeling calm | |
| Patient expressed concern | Including apprehension, worry |
| Patient expressed frustration | Including anger |
| Patient expressed feeling afraid | |
| Patient experienced a sense of significant loss | with regards to the therapy ending |
| Patient expressed feeling hopeless | |
| Patient denied feelings about ending therapy | |
| Therapist encouraged / facilitated patient's | any comment / question by therapist that |

| | |
|---|---|
| expression of affect about ending therapy | prompts the patient to think about how they feel about therapy ending |
| Other | Any other comment that the rater recognises as being relevant to the category but is not applicable to the subcategories defined (e.g. other feelings not specified in the coding scheme) |

Patient made implicit reference to ending therapy

refers to whether the patient describes an event or experience that arguably is thematically linked to the ending of the therapeutic relationship. This is defined more specifically as whether the patient describes the loss of something or someone, their own mortality, or the end of an important relationship (whether in the past, present or future).

Therapist acknowledges the reference, and/or uses it to facilitate further discussion of the patient's feelings about ending therapy.

Other

Problematic termination reactions

| | |
|-----------------------------|--|
| Patient raised new problems | any problem that has not been discussed before |
|-----------------------------|--|

| | |
|--|---|
| Patient wanted to extend length of therapy | (repeated in earlier section on 'discussion of ending') |
|--|---|

Patient devalued therapist / therapy

Patient idealised therapist / therapy

Patient expressed exacerbation of existing / previous

Symptoms

Other

Appendix 6a – Beck Depression Inventory (BDI-II)

Name: _____ Marital Status: _____ Age: _____ Sex: _____
Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

- 0 I do not feel sad.
- 1 I feel sad much of the time.
- 2 I am sad all the time.
- 3 I am so sad or unhappy that I can't stand it.

2. Pessimism

- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

3. Past Failure

- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

4. Loss of Pleasure

- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

- 0 I don't feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6. Punishment Feelings

- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7. Self-Dislike

- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

8. Self-Criticalness

- 0 I don't criticize or blame myself more than usual.
- 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10. Crying

- 0 I don't cry anymore than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.

Subtotal Page 1

Continued on Back

11. Agitation

- 0 I am no more restless or wound up than usual.
- 1 I feel more restless or wound up than usual.
- 2 I am so restless or agitated that it's hard to stay still.
- 3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

- 0 I have not lost interest in other people or activities.
- 1 I am less interested in other people or things than before.
- 2 I have lost most of my interest in other people or things.
- 3 It's hard to get interested in anything.

13. Indecisiveness

- 0 I make decisions about as well as ever.
- 1 I find it more difficult to make decisions than usual.
- 2 I have much greater difficulty in making decisions than I used to.
- 3 I have trouble making any decisions.

14. Worthlessness

- 0 I do not feel I am worthless.
- 1 I don't consider myself as worthwhile and useful as I used to.
- 2 I feel more worthless as compared to other people.
- 3 I feel utterly worthless.

15. Loss of Energy

- 0 I have as much energy as ever.
- 1 I have less energy than I used to have.
- 2 I don't have enough energy to do very much.
- 3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

- 0 I have not experienced any change in my sleeping pattern.
- 1a I sleep somewhat more than usual.
- 1b I sleep somewhat less than usual.
- 2a I sleep a lot more than usual.
- 2b I sleep a lot less than usual.
- 3a I sleep most of the day.
- 3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

- 0 I am no more irritable than usual.
- 1 I am more irritable than usual.
- 2 I am much more irritable than usual.
- 3 I am irritable all the time.

18. Changes in Appetite

- 0 I have not experienced any change in my appetite.
- 1a My appetite is somewhat less than usual.
- 1b My appetite is somewhat greater than usual.
- 2a My appetite is much less than before.
- 2b My appetite is much greater than usual.
- 3a I have no appetite at all.
- 3b I crave food all the time.

19. Concentration Difficulty

- 0 I can concentrate as well as ever.
- 1 I can't concentrate as well as usual.
- 2 It's hard to keep my mind on anything for very long.
- 3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

- 0 I am no more tired or fatigued than usual.
- 1 I get more tired or fatigued more easily than usual.
- 2 I am too tired or fatigued to do a lot of the things I used to do.
- 3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

- 0 I have not noticed any recent change in my interest in sex.
- 1 I am less interested in sex than I used to be.
- 2 I am much less interested in sex now.
- 3 I have lost interest in sex completely.

Subtotal Page 2

Subtotal Page 1

Total Score

Appendix 6b – Hospital Anxiety and Depression Scale (HADS)

Hospital Anxiety and Depression Scale (HADS)

Patients are asked to choose one response from the four given for each interview. They should give an immediate response and be dissuaded from thinking too long about their answers. The questions relating to anxiety are marked "A", and to depression "D". The score for each answer is given in the right column. Instruct the patient to answer how it currently describes their feelings.

| | | |
|---|---------------------------------|---|
| A | I feel tense or 'wound up': | |
| | Most of the time | 3 |
| | A lot of the time | 2 |
| | From time to time, occasionally | 1 |
| | Not at all | 0 |

| | | |
|---|---|---|
| D | I still enjoy the things I used to enjoy: | |
| | Definitely as much | 0 |
| | Not quite so much | 1 |
| | Only a little | 2 |
| | Hardly at all | 3 |

| | | |
|---|--|---|
| A | I get a sort of frightened feeling as if something awful is about to happen: | |
| | Very definitely and quite badly | 3 |
| | Yes, but not too badly | 2 |
| | A little, but it doesn't worry me | 1 |
| | Not at all | 0 |

| | | |
|---|---|---|
| D | I can laugh and see the funny side of things: | |
| | As much as I always could | 0 |
| | Not quite so much now | 1 |
| | Definitely not so much now | 2 |
| | Not at all | 3 |

| | | |
|---|---------------------------------------|---|
| A | Worrying thoughts go through my mind: | |
| | A great deal of the time | 3 |
| | A lot of the time | 2 |
| | From time to time, but not too often | 1 |
| | Only occasionally | 0 |

| | | |
|---|------------------|---|
| D | I feel cheerful: | |
| | Not at all | 3 |
| | Not often | 2 |
| | Sometimes | 1 |
| | Most of the time | 0 |

| | | |
|---|-------------------------------------|---|
| A | I can sit at ease and feel relaxed: | |
| | Definitely | 0 |
| | Usually | 1 |
| | Not Often | 2 |
| | Not at all | 3 |

| | | |
|---|--------------------------------|---|
| D | I feel as if I am slowed down: | |
| | Nearly all the time | 3 |
| | Very often | 2 |
| | Sometimes | 1 |
| | Not at all | 0 |

| | | |
|---|---|---|
| A | I get a sort of frightened feeling like 'butterflies' in the stomach: | |
| | Not at all | 0 |
| | Occasionally | 1 |
| | Quite Often | 2 |
| | Very Often | 3 |

| | | |
|---|--|---|
| D | I have lost interest in my appearance: | |
| | Definitely | 3 |
| | I don't take as much care as I should | 2 |
| | I may not take quite as much care | 1 |
| | I take just as much care as ever | 0 |

| | | |
|---|--|---|
| A | I feel restless as I have to be on the move: | |
| | Very much indeed | 3 |
| | Quite a lot | 2 |

| | | |
|--------------------------|---------------|---|
| <input type="checkbox"/> | Not very much | 1 |
| <input type="checkbox"/> | Not at all | 0 |

| | | |
|--------------------------|---|---|
| D | I look forward with enjoyment to things: | |
| <input type="checkbox"/> | As much as I ever did | 0 |
| <input type="checkbox"/> | Rather less than I used to | 1 |
| <input type="checkbox"/> | Definitely less than I used to | 2 |
| <input type="checkbox"/> | Hardly at all | 3 |

| | | |
|--------------------------|--|---|
| A | I get sudden feelings of panic: | |
| <input type="checkbox"/> | Very often indeed | 3 |
| <input type="checkbox"/> | Quite often | 2 |
| <input type="checkbox"/> | Not very often | 1 |
| <input type="checkbox"/> | Not at all | 0 |

| | | |
|--------------------------|--|---|
| D | I can enjoy a good book or radio or TV program: | |
| <input type="checkbox"/> | Often | 0 |
| <input type="checkbox"/> | Sometimes | 1 |
| <input type="checkbox"/> | Not often | 2 |
| <input type="checkbox"/> | Very seldom | 3 |

| | | |
|--|--|--|
| | Scoring (add the As = Anxiety. Add the Ds = Depression). The norms | |
|--|--|--|

| | | |
|--|---|--|
| | below will give you an idea of the level of Anxiety and Depression. | |
| | 0-7 = Normal | |
| | 8-10 = Borderline abnormal | |
| | 11-21 = Abnormal | |
| | | |

Reference:

Zigmond and Snaith (1983)

Appendix 7 – Example of transcription of termination related data

Pt 1

189: Th: One of the things I'd like to do given that this is our last regular session, is make sure we review the goals we set, how far we got with them, we've done quite a lot of that already in the sessions leading up to today, preparing for the end point, but talking about symptoms...I think this was one of the goals we were working towards from the start, I think you've achieved a great deal

215: Pt: There have been occasional moments where I have felt low, but this has been occasional, cos other evenings I've been fine, have kept busy, doing other stuff rather than sitting in the chair

224: Pt: Walking to get my tea break today I felt very flat, I don't know why

235: Pt: I don't feel as guilty as I was before, I feel I've given what I can give, I've distanced myself from my brother and don't feel the need to see them as often which helps

242: Th: So that's a good change then

253: Pt: I've never had suicidal thoughts, I have had thoughts 'it's all gonna go wrong, it's all gonna end' though over the last couple of weeks

261: Pt: My sleep's still not great, I'm waking up a lot during the night, it's maybe to do with coming off the pills, I suppose it's not quite so bad as it was, but I'm having a lot of anxious dreams at the moment, where a lot of bad things happen

303: Pt: the one good thing is I'm not falling asleep so much at work

304: Th: that's a change from when we first started though, falling asleep during the day was almost a daily struggle then, so to get the occasional day now is quite a step forward. Do you feel you're keeping up with the tasks at home?

311: Pt: I've taken on a lot and sometimes I feel it's all a bit much, the ball's rolling too fast. But at least now I am doing something

321: Th: So that's another difference then, maybe now the priority is how to pace things

327: Th: What about social things?

328: Pt: That's the one bit I feel I haven't got back, it's still strained a bit and I find myself rabbiting on....

Appendix 8 – Example of completed coding scheme

| <u>Termination component / item</u> | Occurrence Record number of data unit (derived from tape counter transcription) |
|---|--|
| Discussion of the end of therapy | |
| The end was a significant event in therapy | yes |
| The end was used to process patient's experience of loss | no |
| Patient wanted to extend length of therapy | |
| Therapist mentions ending therapy Or comments session being last (or last but one) | 189 |
| Patient mention ending therapy Or comments session being last (or last but one) | |
| Other | |
| Evaluation of therapy | |
| Therapist summarised the work; (changes noticed/ what learned) | 242, 304, 321 |
| Patient summarised the work; changes made/noticed, what learned | 215, 235, 303, 311 |
| Patient and therapist assessed the extent to which goals had been attained | 189, 261, 328 |
| Patient stated things he/she liked about therapy | |
| Patient stated things he/she disliked about therapy | |
| Patient asked questions about how therapy works | |
| Other (e.g. therapist asks patient to evaluate therapy) | 327 |
| Closure in the therapist-patient relationship | |
| Patient thanked the therapist | |

| | |
|---|--|
| | |
| Therapist thanked the patient | |
| Therapist shared feelings about therapy with patient | |
| Patient asked personal questions about therapist | |
| Patient gave gift to therapist | |
| Patient wanted to mark the end of therapy | |
| other | |
| Discussion of plans for the future | |
| Therapist and patient discussed patient's plans for the future | |
| Therapist suggested other types of help for patient | |
| Patient wanted opportunity for future contact with therapist | |
| Patient plans to receive more therapy in the future | |
| Therapist commented on relapse / relapse prevention Includes therapist giving advice to patient about relapse prevention | |
| Patient commented on relapse / relapse prevention | |
| Other | |
| Patient expression of affect about the end of therapy | |
| Patient shared feelings about ending therapy | |
| Patient expressed feeling healthy about ending therapy | |

| | |
|---|-----|
| | |
| Patient expressed pride (<i>accomplishment, independence</i>) | |
| Patient expressed feeling calm | |
| Patient expressed concern (<i>apprehension, worry</i>) | |
| Patient expressed frustration | |
| Patient expressed feeling afraid | |
| Patient experienced a sense of significant loss | |
| Patient expressed feeling alone | |
| Patient expressed feeling hopeless | |
| Patient denied feelings about the end of therapy | |
| Therapist encouraged/ facilitated patient's expression of affect about ending therapy | |
| other | |
| Patient made implicit reference to ending therapy | |
| Patient made an implicit reference to ending therapy (loss of someone or something, end of significant relationship-past/present/future - awareness of own mortality) | 253 |
| Therapist acknowledges the implicit reference, and/or uses it to facilitate further discussion of the patient's feelings about ending therapy. | |
| other | 224 |

| | |
|--|--|
| Problematic termination reactions | |
| Patient raised new problems | |
| Patient wanted to extend length of therapy | |
| Patient devalued therapist / therapy | |
| Patient idealized therapist / therapy | |
| Patient expressed exacerbation of existing / previous symptoms | |
| Other | |

Appendix 9 – Examples of coding process

Coding examples

IPT session 16 PtMT (Transcript 6)

| | Coding category (item) |
|--|--|
| 120: Pt: I do kind of have a feeling if I carry on like this [I'll find myself in difficulty again] | Discussion of future (patient comments on relapse) |
| 196: Pt: Ok, [still think there are things I can keep working on though]. I need to try and work at one thing at a time. Some things I've worked on, he's gone back on... | Evaluation (patient assessed goals attained) |
| 228: Th: this [last meeting] really is to round things up, [summarise what we've done really], for you to take away, ok, we did a little bit of that last week | Discussion of ending (therapist mentions end) Evaluation (other) |
| 232: Th: [I think you've picked up on the model really well], and [you're gonna be able to work with it, but you have to keep working on it.] Its up to you to keep working on it | Evaluation (therapist summarised work) Discussion of future (therapist comments relapse) |
| 243: Pt: I will have to schedule in time to remember to do things I'm supposed to do...e.g. remember how to do things | Discussion of future (patient comments relapse) |
| 247: Th: that'll be good, just sit down, say 'how am I doing with the model?'. It is difficult to pick it up and change your life, but you do get pleasure from doing it | Discussion of future (therapist comments relapse - advice) |
| 260: Pt: at the moment, the model, I mean its different when I'm depressed, but at them moment, the passive thing served a purpose for me, which was wanting everyone to decide for themselves without me prompting. I'm a bit like that in everything, and [I will need to be more hands on, I know Joanna loves me, this changing to asking, making sure people know what I'm wanting from them, I feel like I'm going to do it now...but its going to be difficult] | Discussion of future (patient comments relapse prevention) |
| 318: Th: do you still have that core belief? | Evaluation (therapist assessed goals attained) |
| 321: Pt: [I don't think I do]. Or maybe at the moment I would like to leave it behind but its maybe still lurking there somewhere, and [I'll need to watch out for it] | Evaluation (patient assessed goals attained) Discussion of future (patient comments relapse prevention) |
| 338: Th: [But sometimes you will slip back, but that's normal]...sometimes it is difficult to give up the past. | Discussion of future (therapist comments relapse) |

377: Th: [but also try and fit into that model what it feels like, feel that, when it hurts, which is sometimes enough to allow you to move on.] Some things do hurt, they are sad, and there are no solutions to that. [You can feel it, stick with it]

Discussion about future (therapist comments relapse)

388: Th: [you need to learn to ask for help. Up to you to go out there and ask]

Discussion about future (therapist comments relapse)

394: Pt: it's interesting, [I've seen how Louise appreciates me asking for help. That's quite useful to hear, that I'm not burdening someone]

Evaluation (patient summarises work)

405: Pt: Dave and Joanna have also given me some useful feedback. [Joanna has even taken on the model, and noticed me scoring 'not depressed' for the first time!] (laughing)

Evaluation (patient summarises work)

414: Th: can you recognise the early warning signs of depression?

Discussion about future (therapist comments relapse)

416: Pt: sometimes. It depends if it comes on quickly, [usually its when I feel like things are going ok, that's always a terrible warning sign that it's going to crumble!] I'm not sure how it works, maybe some small things makes me conscious of doing well. Then there's the expectation of something going wrong

Discussion about future (patient comments relapse)

434: Pt: I thought that the other day, [that has the potential of going completely wrong]. And it will, I can't think what it was

Discussion about future (therapist comments relapse)

441: Pt: I've got this thing that time seems longer, and I like that, cos [its scary if you think that life starts whizzing by, hurtling towards the end of it], it all seems so quick...it seems a long time since I was here last

Patient makes implicit reference to ending

452: Pt: I've not been hassling myself to do things, I don't know if that's a conscious thing

Evaluation (patient summarised work – changes noticed)

457: Th: I think the guilt has been lifted, and that's going to have a big impact

Evaluation (therapist summarised work – changes noticed)

458: Th: If I go back to the early warning signs, have you noticed anything in your mood?

Discussion about future (therapist comments relapse)

461: Pt: quite often I feel more irritable, I start reacting to little things

Discussion about future (patient comments relapse)

463: Th: that's probably a warning sign

Discussion about future (therapist comments relapse)

| | |
|--|--|
| 478: Th: so dreams might be an early warning sign? | Discussion about future (therapist comments relapse) |
| 481: Th: how about your level of energy? | Discussion about future (therapist comments relapse) |
| 482: Pt: that could be a warning sign. Level of energy hasn't been great this week. It could be a sign, means I'm not doing enough | Discussion about future (patient comments relapse) |
| 492: Th: [with this being our last week] , it might be useful for me to fill this in, to keep track of your symptoms, e.g. energy wise | Discussion of ending (therapist mentions ending) |
| 497: Th: what can you do if you feel something coming on? | Discussion about future (therapist comments relapse) |
| 498: Pt: I think its important I see people making an effort. Go to the office, having people to relate to | Discussion about future (patient comments relapse) |
| 506: Th: that's very important, especially cos you isolate yourself a lot | Discussion about future (therapist comments relapse) |
| 510: Th: how about the school board? Are there opportunities to meet new people? | Discussion about future (therapist discusses patient's future plans) |
| 512: Pt: they're all new to me, it's all completely new to me, but I'm still learning what to do. Don't really know what school boards do, that'll be interesting | Discussion about future (patient discusses future plans) |
| 527: Th: that's the thing about the job, being out, having contact with people, and also being active | Discussion about future (therapist discusses patient's future plans) |
| 531: Th: what else can you do to protect yourself? | Discussion about future (therapist comments relapse) |
| 533: Pt: [we'll see my friends more] . Also I feel guilty about not writing to people e.g. in Zimbabwe. I feel better after | Discussion about future (patient discusses future plans) |
| 544: Pt: I just haven't been feeling guilty. Maybe the drug has helped, or maybe I made a conscious decision, I don't know | Evaluation (patient summarised work – changes noticed) |
| 545: Th: or maybe a bit of both | Evaluation (therapist summarised work) |
| 546: pt: the drug on its own is not enough. I have to decide to be active. I think it'll be easier, [I've got less negativity about things. But I've still got fear about things] . I was quite nervous at the invigilator's meeting, but [maybe it'll get easier] | Evaluation (patient assessed extent goals attained) |
| | Discussion of future (patient comments relapse) |

558: Th: but it just helps you to go out there, and be more active (talking about medication), [give you the courage to go out there and use the model]

562: Th: what are the things you worry about, not coming here?

563: Pt: the thing that [worries me] is I might forget to think about it. [Which is why I need to make a time to think about it. Just to remind myself], which is why I should have taken notes

575: Th: (offers tape of the session to patient), it will help you to remember, and you can send it back to me

583: Th: it will be interesting to see if you pick up on the [change I see in you]

588: Pt: one of the things I hated was [seeing how reasonable I was about everything, I don't have to be like that]. It's nauseating

596: Th: you were doing it constantly, looking after others, hoping they'd look after you. You felt resentment. That was a major thing for you, and from that point on you shifted yourself. It's not being unreasonable, its looking after yourself, making yourself just as important as someone else.

610: Pt: [but someone's who's constantly reasonable, its too good to be real. Maybe that's what I've picked up if I'm upset I should say, and that would be real.] I said my Father was always losing his temper, I don't want to be like that, but there is a danger of losing communication with people. You don't know what's going on underneath

628: Th: It's good to keep repeating yourself, how do I feel. Sometimes step back, take time out, say, 'how do I feel?' Ask for support to help you with it

636: Th: [I think you're doing really well, I'm hopeful. I think you've learned a lot], [but its really up to you to use it. To go out here, and be active. If you do, then I think you'll be really fine]

Discussion of future (therapist comments relapse prevention)

Expression of affect about ending (therapist facilitates)

Expression of affect (patient expresses feelings; worry / concern)

Discussion of future (patient comments relapse prevention)

Discussion of future (therapist comments relapse prevention)

Evaluation of therapy (therapist summarised work)

Evaluation of therapy (patient summarised work)

Evaluation of therapy (therapist summarised work)

Evaluation of therapy (patient summarised the work)

Discussion of future (therapist comments relapse prevention)

Evaluation of therapy (therapist summarised the work)

Discussion of future (therapist comments relapse prevention)

645: Pt: what I want to know is that people who aren't depressed, are they using the model without knowing it?

650: Pt: are people using a model, ie asking for help?

658: Pt: do people have these skills already?

682: Pt: I feel much more level

695: Th: try saying the drug will allow me to apply the model in my life. Most people do better 6 months after finishing treatment

701: Pt: that's useful to think things can keep getting better

704: Th: But you can get tools, and keep using them, but it will take a while

710: Pt: **[I think I need to take one thing at a time, small things and apply the model to them]**, these very small things, I need to feel pleased with even the small things

Evaluation of therapy (patient asked question about how therapy works)

Evaluation of therapy (patient asked question about how therapy works)

Evaluation of therapy (patient asked question about how therapy works)

Evaluation of therapy (patient summarised work)

Discussion of future (therapist comments relapse prevention)

Discussion of future (patient comments relapse prevention)

Discussion of future (therapist comments relapse prevention)

Discussion of future (patient comments relapse prevention)

Appendix 10 – Calculation for percentage agreement (reliability analysis)

Formula for simple percent agreement (Neuendorf, 2002, p.154)

Percent Agreement = (Total number of agreements between coders / total number of units coded) x 100

Appendix 11 – Item total correlation coefficients for items within each category of the coding scheme

Corrected item total correlation coefficients for items within each category of the coding scheme

1. Table illustrating the alpha correlation of items within the category discussion of the end of therapy

| | Corrected Item-Total Correlation | Cronbach's Alpha if Item Deleted |
|----------------------------------|----------------------------------|----------------------------------|
| Patient wanted to extend therapy | .401 | .317 |
| Therapist mentioned ending | .158 | .551 |
| Patient mentioned ending | .490 | .263 |
| Other | .189 | .501 |

2. Table illustrating the alpha correlation of items within the category evaluation of therapy

| | Corrected Item-Total Correlation | Cronbach's Alpha if Item Deleted |
|---|----------------------------------|----------------------------------|
| Therapist summarises the work | .753 | .464 |
| Patient summarises the work | .678 | .503 |
| Patient and therapist assessed goals | .590 | .537 |
| Patient stated likes | -.125 | .699 |
| Patient stated dislikes | -.080 | .682 |
| Patient asked therapist questions about how therapy works | .002 | .678 |
| Other | .415 | .619 |

3. Table illustrating the alpha correlation of items within the category closure of the therapist-patient relationship

| | Corrected Item-Total Correlation | Cronbach's Alpha if Item Deleted |
|--|--|--|
| Patient thanked therapist | .773 | .382 |
| Therapist thanked patient | .474 | .589 |
| Therapist shared feelings about therapy | .405 | .538 |
| Patient asked therapist personal questions | .226 | .606 |
| Patient gave therapist gift | .570 | .593 |
| Patient wanted to mark the end of therapy | .000 | .624 |
| Other | .563 | .575 |

4. Table illustrating the alpha correlation of items within the category discussion of plans for the future

| | Corrected Item-Total Correlation | Cronbach's Alpha if Item Deleted |
|--|--|--|
| Discussed plans | .183 | .530 |
| Therapist suggested other types of help | .284 | .460 |
| Patient wants further contact with therapist | -.080 | .475 |
| Patient plans to receive more therapy | -.028 | .477 |
| Therapist commented on relapse | .533 | .162 |
| Patient commented on relapse | .656 | .164 |
| Other | -.029 | .473 |

5. Table illustrating the alpha correlation of items within the category expression of affect about the end of therapy

| | Corrected Item-Total Correlation | Cronbach's Alpha if Item Deleted |
|--|----------------------------------|----------------------------------|
| Expressed feelings | .770 | .540 |
| Healthy | .289 | .664 |
| Pride | .322 | .663 |
| Calm | .087 | .683 |
| Concern/worry | .382 | .649 |
| Frustration | .305 | .666 |
| Afraid | .240 | .670 |
| Loss/sadness | .303 | .665 |
| Alone | .123 | .680 |
| Hopeless | .140 | .679 |
| Denied feelings | .135 | .679 |
| Therapist facilitated expression of feelings | .510 | .621 |
| Other | .238 | .670 |

6. Cronbach's alpha was not computed on items within the category implicit reference to the end of therapy, as there are only 3 items in the category and Cronbach's alpha requires a minimum of 4 items.

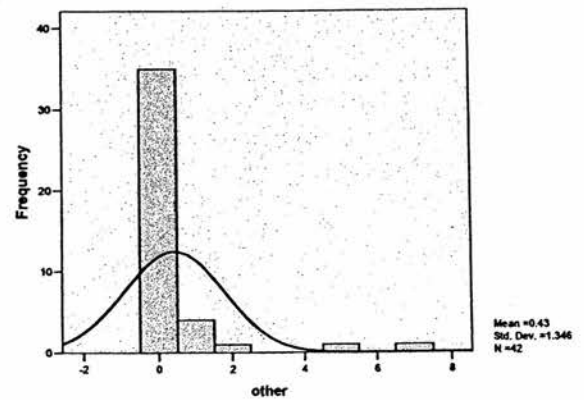
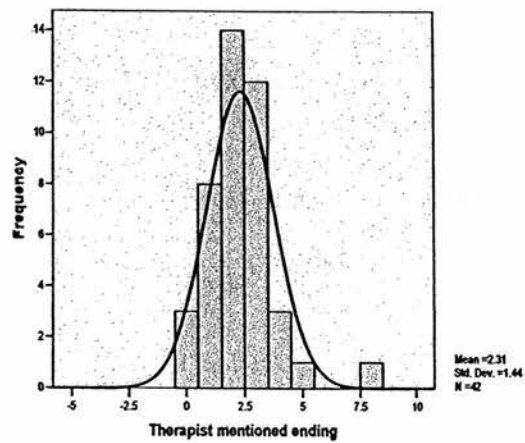
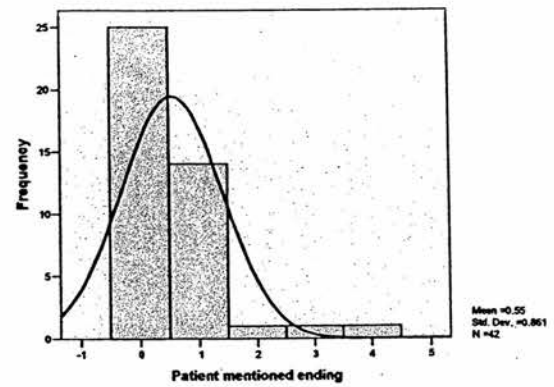
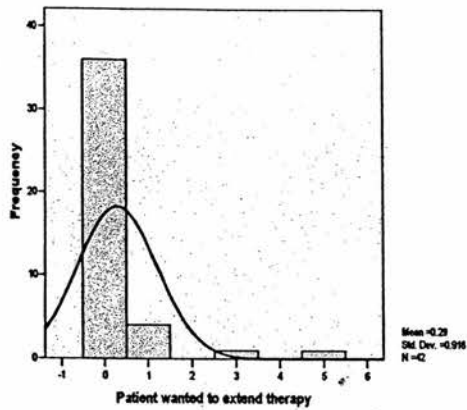
7. Table illustrating the alpha correlation of items within the category problematic termination reaction

| | Corrected Item-Total Correlation | Cronbach's Alpha if Item Deleted |
|--|----------------------------------|----------------------------------|
| Patient discussed new problems | .187 | .507 |
| Patient wanted to extend therapy | .172 | .525 |
| Patient devalued therapy/therapist | .165 | .513 |
| Patient idealised therapy/therapist | -.001 | .549 |
| Patient described an exacerbation of previous symptoms | .462 | .358 |
| other | .779 | .262 |

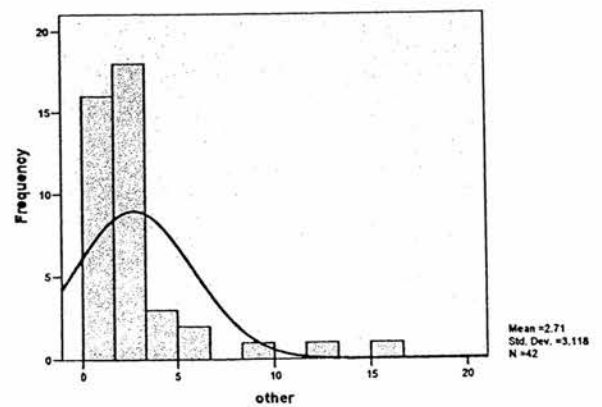
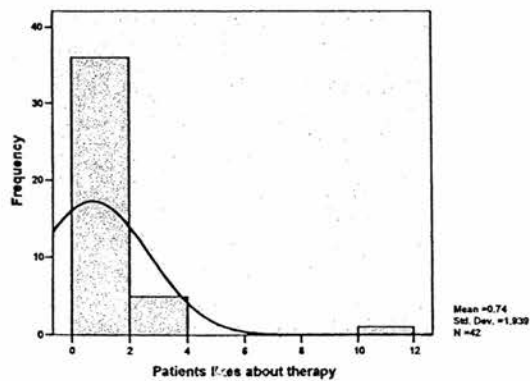
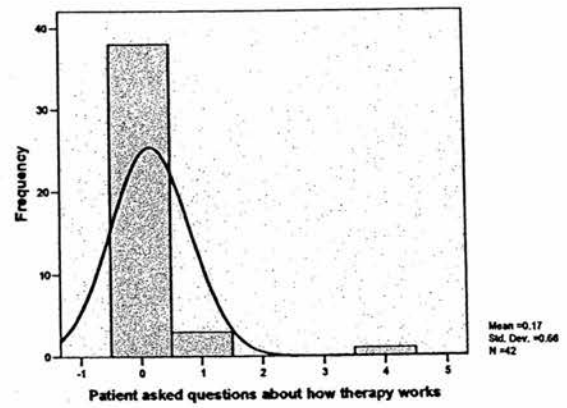
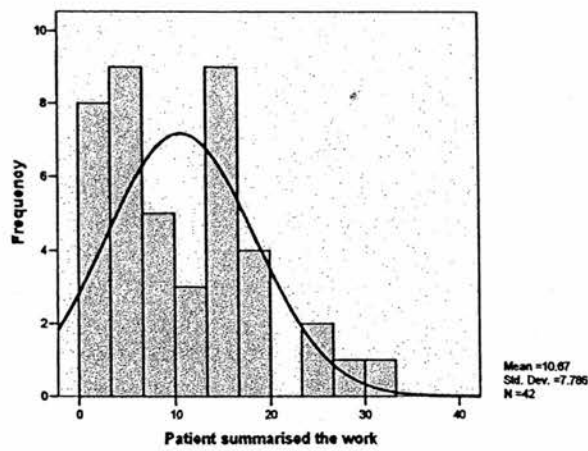
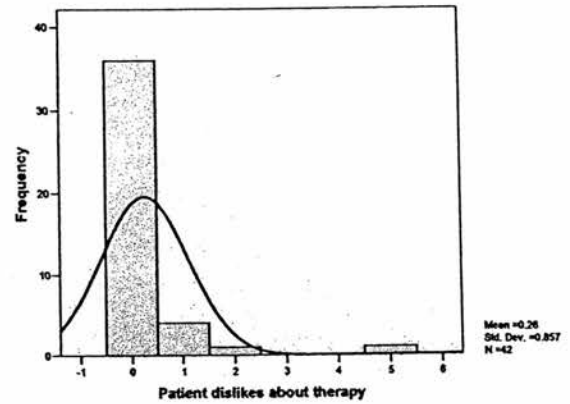
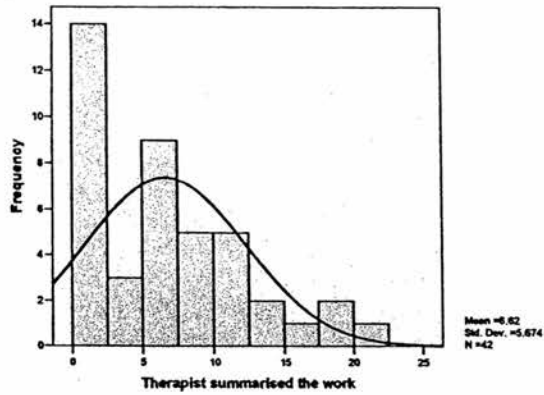
Appendix 12 – Histograms of items within each category

Histograms showing frequency distribution of items per category

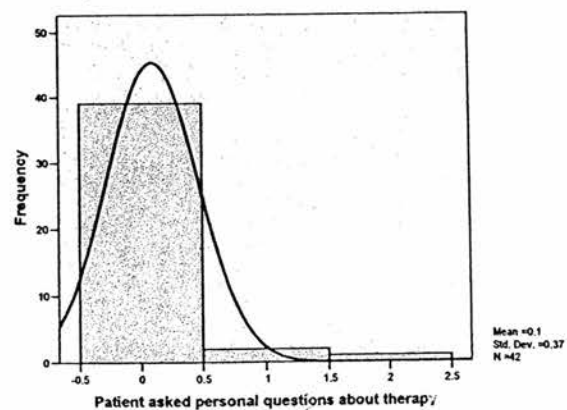
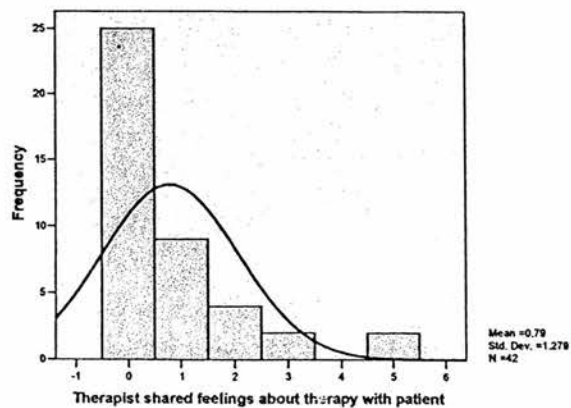
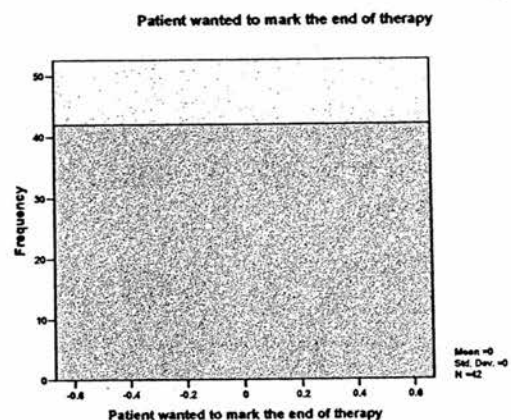
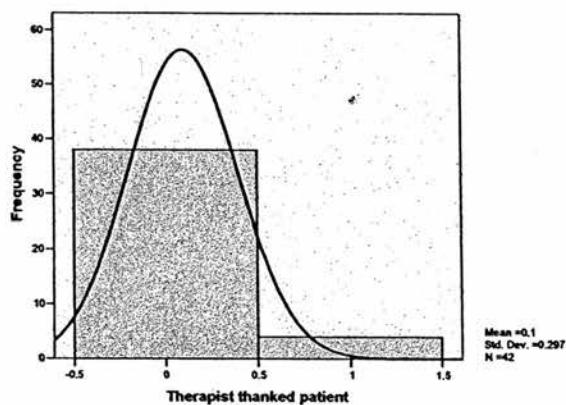
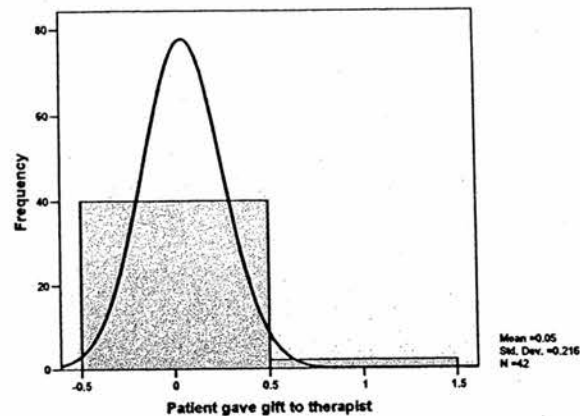
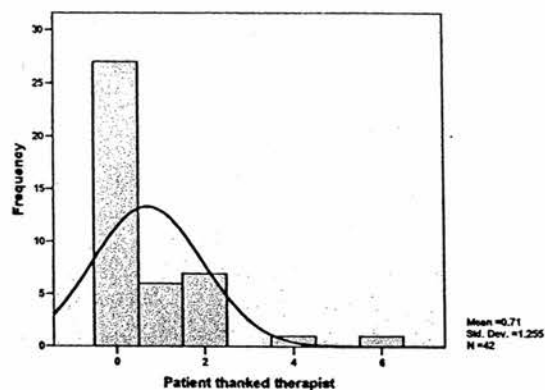
1. Discussion of end of therapy

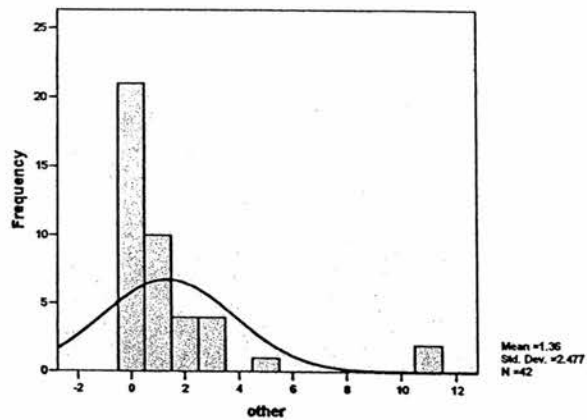


2. Evaluation

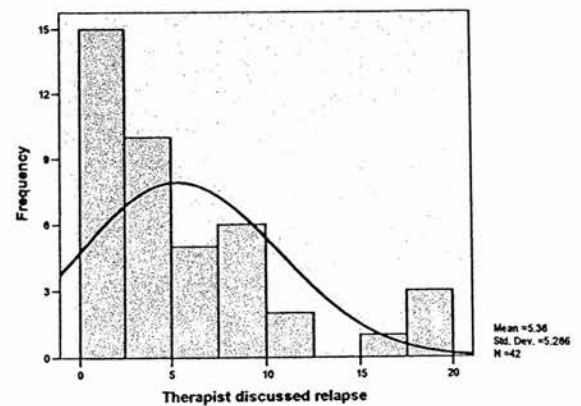
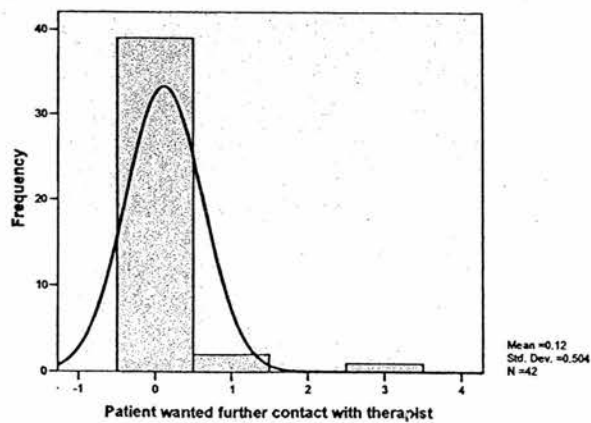
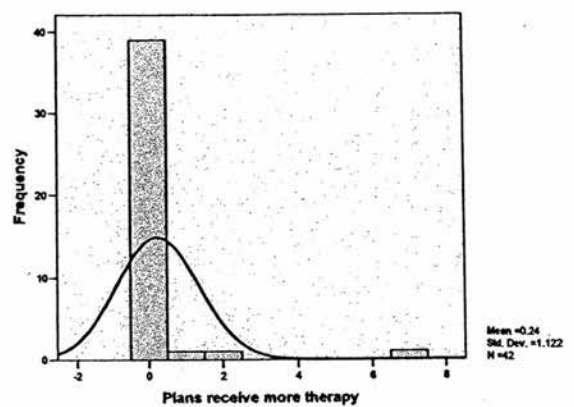
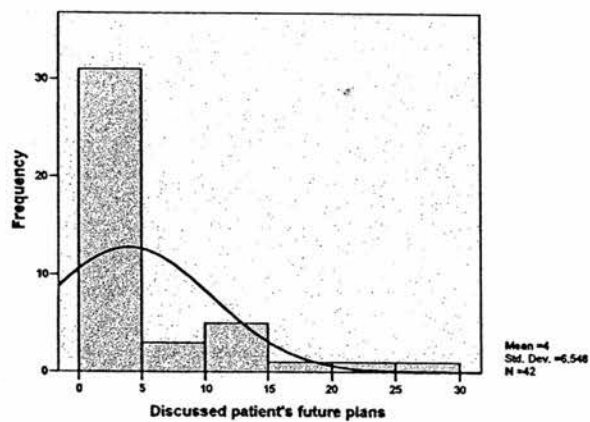


3. Closure of therapeutic relationship

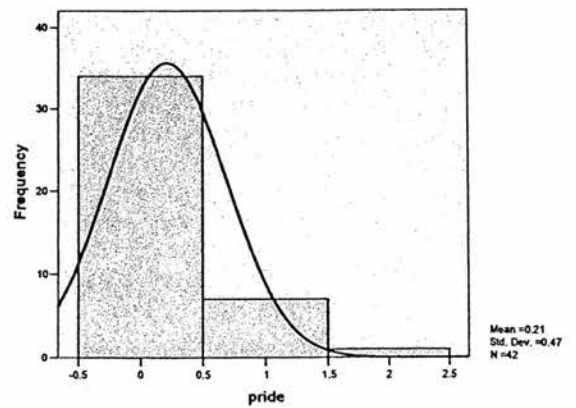
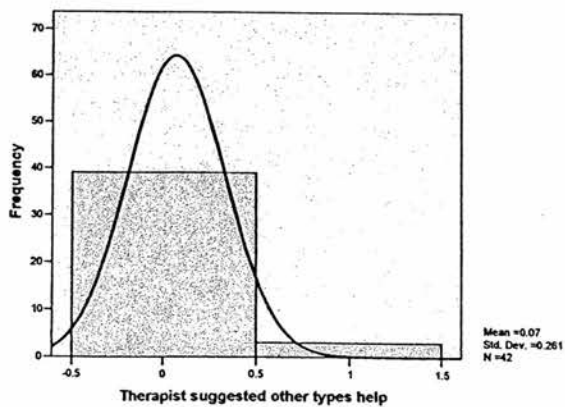
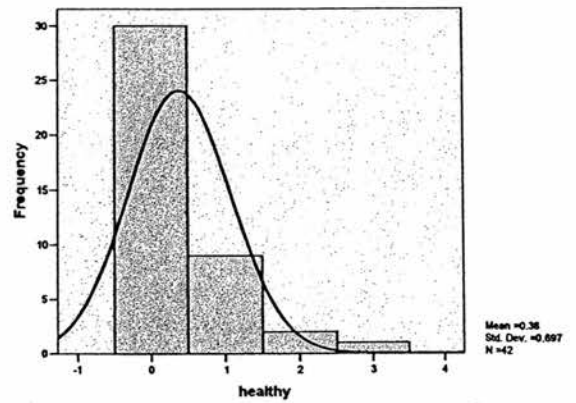
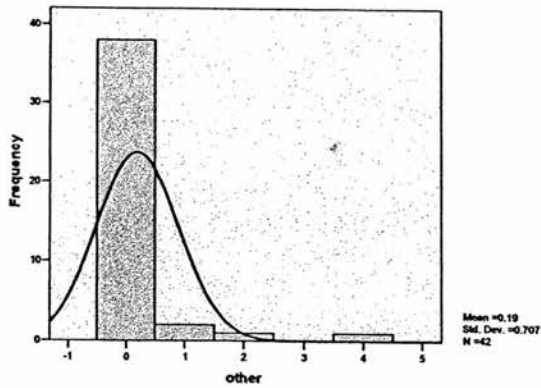
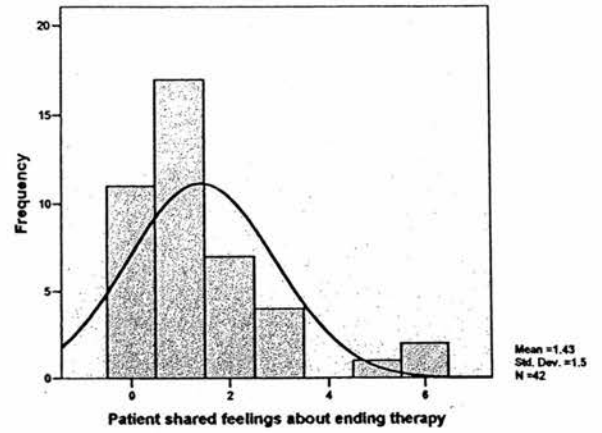
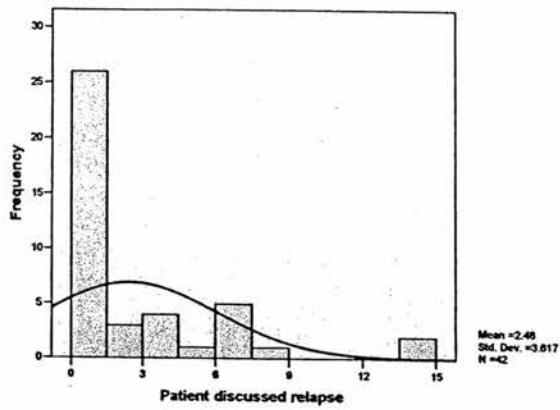


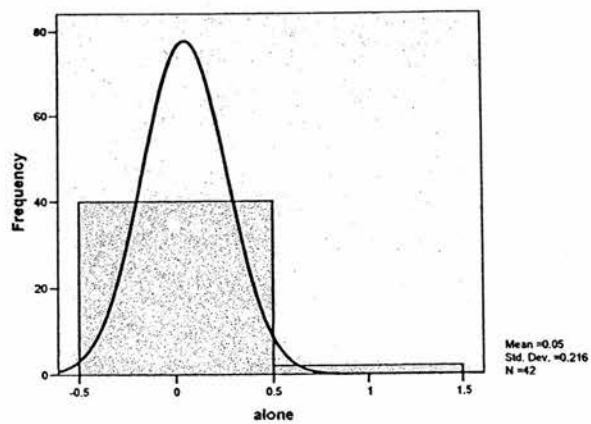
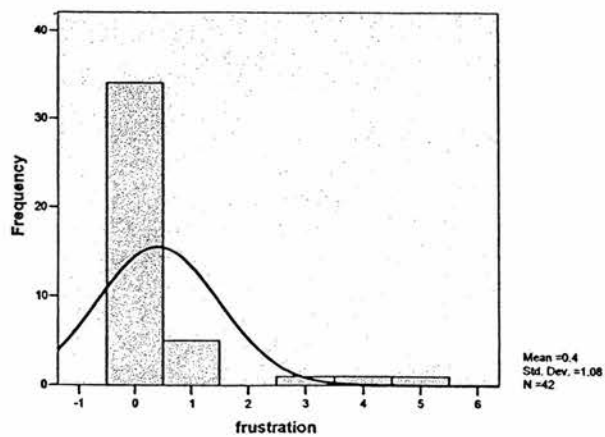
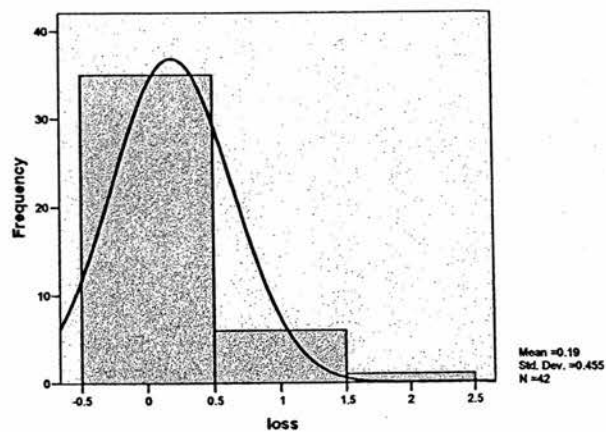
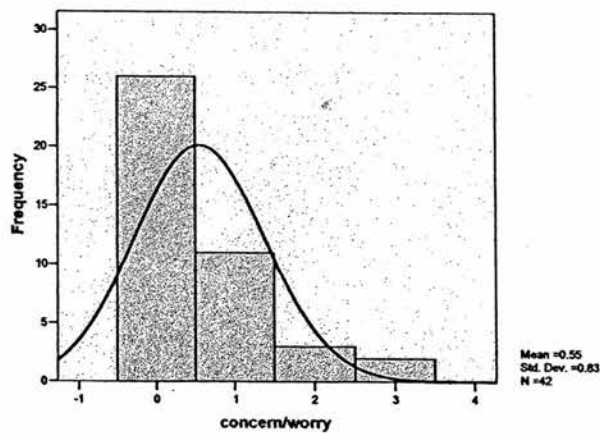
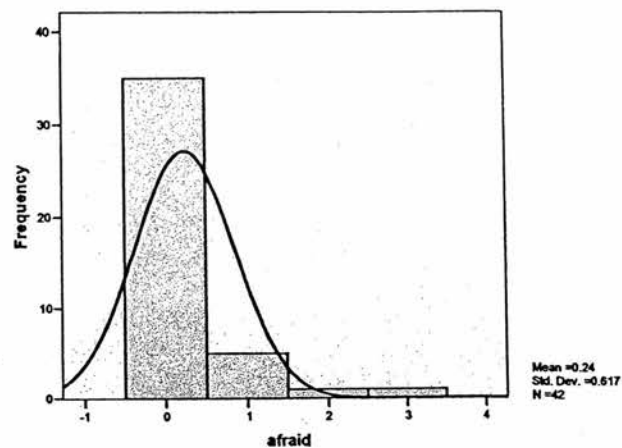
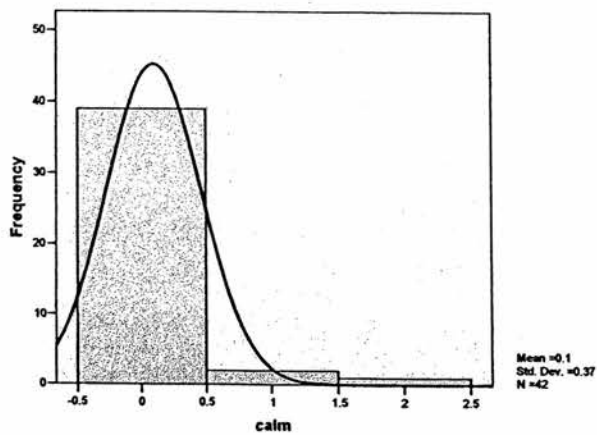


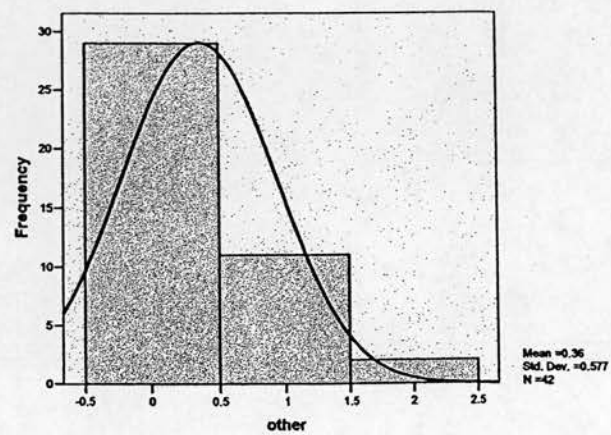
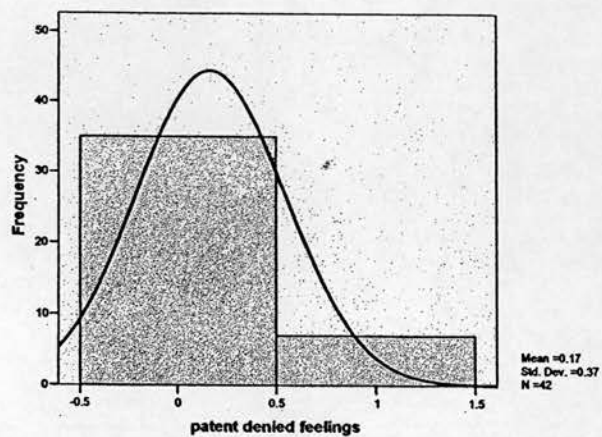
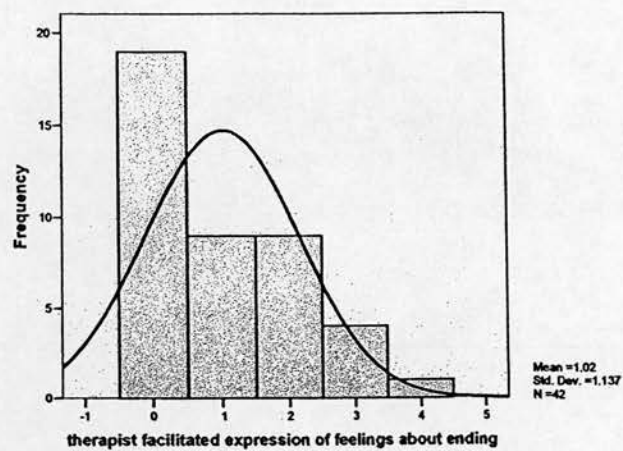
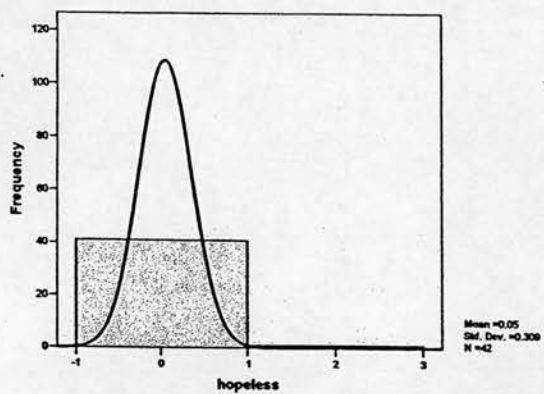
4. Discussion of plans for the future



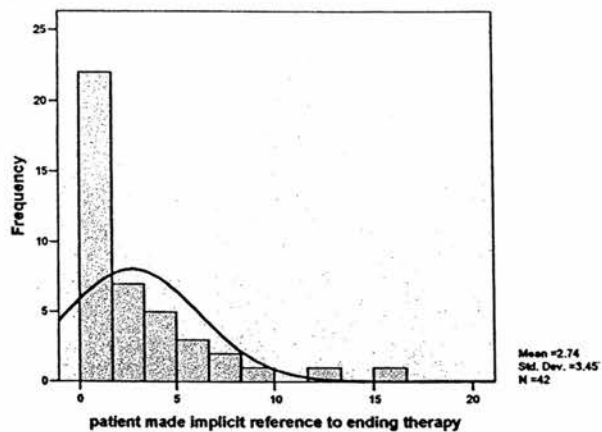
5. Expression of affect about ending







6. Implicit reference to ending therapy



7. Problematic termination reaction

